direction and immediate supervision of a licensed physician.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1270(B)(6) and 37:3351-3361.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Board of Medical Examiners, LR 12:767 (November 1986), amended, by the Department of Health and Hospitals, Board of Medical Examiners, LR 25:2224 (November 1999), LR 38:62 (January 2012).

§5509. Prohibitions

A. A licensed respiratory therapist shall not:

1. undertake to perform or actually perform any activities described in §2503 of these rules, definition of "Respiratory therapy," except upon a prescription or other order of a physician, advanced registered nurse or physician assistant;

2. administer any drugs or medications except as dispensed by a pharmacist and prescribed by a physician, advanced practice registered nurse or physician assistant; or

3. perform any surgical incisions.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1270(B)(6) and 37:3351-3361.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Board of Medical Examiners, LR 12:767 (November 1986), amended by the Department of Health and Hospitals, Board of Medical Examiners, LR 25:2224 (November 1999), LR 38:63 (January 2012).

Subchapter C. Grounds for Administrative Action

§5517. Causes for Administrative Action

A. The board may deny, refuse to issue, renew, or reinstate, or may suspend, revoke or impose probationary conditions and restrictions on the license, temporary license (examination permit), or temporary work permit of any respiratory therapist if the licensee or applicant for license has been guilty of unprofessional conduct which has endangered or is likely to endanger the health, welfare, or safety of the public.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1270(B)(6) and 37:3351-3361.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Board of Medical Examiners, LR 12:767 (November 1986), amended by the Department of Health and Hospitals, Board of Medical Examiners, LR 17:886 (September 1991), LR 25:2225 (November 1999), LR 38:63 (January 2012).

§5519. Causes for Action; Definitions; Unprofessional Conduct

A. As used herein, the term *unprofessional conduct* by a respiratory therapist or applicant shall mean any of the causes set forth in R.S. 37:3358 of the Act.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1270(B)(6) and 37:3351-3361.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Board of Medical Examiners, LR 12:767 (November 1986), amended by the Department of Health and Hospitals, Board of Medical Examiners, LR 17:886 (September 1991), LR 25:2225 (November 1999), LR 38:63 (January 2012).

Robert L. Marier, M.D.
Executive Director

1201#081

RULE

Department of Health and Hospitals
Bureau of Health Services Financing

Home and Community-Based Services Providers
Minimum Licensing Standards
(LAC 48:I.Chapter 50)

The Department of Health and Hospitals, Bureau of Health Services Financing has adopted LAC 48:I.Chapter 50 in the Medical Assistance Program as authorized by R.S. 36:254 and R.S. 40:2120.2. This Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq.

Title 48
PUBLIC HEALTH–GENERAL
Part 1. General Administration
Subpart 3. Licensing and Certification
Chapter 50. Home and Community-Based Services Providers Licensing Standards
Subchapter A. General Provisions

§5001. Introduction

A. Pursuant to R.S. 40:2120.2, the Department of Health and Hospitals hereby establishes the minimum licensing standards for home and community-based services (HCBS) providers. These licensing provisions contain the core requirements for HCBS providers as well as the module-specific requirements, depending upon the services rendered by the HCBS provider. These regulations are separate and apart from Medicaid standards of participation or any other requirements established by the Medicaid Program for reimbursement purposes.

B. Any person or entity applying for an HCBS provider license or who is operating as a provider of home and community-based services shall meet all of the core licensing requirements contained in this Chapter, as well as the module-specific requirements, unless otherwise specifically noted within these provisions.

C. Providers of the following services shall be licensed under the HCBS license:

1. adult day care (ADC);
2. family support;
3. personal care attendant (PCA);
4. respite;
5. substitute family care (SFC);
6. supervised independent living (SIL), including the shared living conversion services in a waiver home; and
7. supported employment.

D. The following entities shall be exempt from the licensure requirements for HCBS providers:

1. any person, agency, institution, society, corporation, or group that solely:
   a. prepares and delivers meals;
   b. provides sitter services; or
   c. provides housekeeping services;
2. any person, agency, institution, society, corporation, or group that provides gratuitous home and community-based services;

3. any individual licensed practical nurse (LPN) or registered nurse (RN) who has a current Louisiana license in good standing;

4. staffing agencies that supply contract workers to a health care provider licensed by the department; and

5. any person who is employed as part of a departmentally authorized self-direction program;

a. For purposes of these provisions, a self-direction program shall be defined as a service delivery option based upon the principle of self-determination. The program enables participants and/or their authorized representative(s) to become the employer of the people they choose to hire to provide supports to them.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2120.1.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:63 (January 2012).

§5003. Definitions

Accredited—the process of review and acceptance by an accreditation body such as the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), the Commission on Accreditation of Rehabilitation Facilities (CARF) or Council on Accreditation (COA).

Activities of Daily Living—the functions or tasks which are performed either independently or with supervision that assist an individual to live in a community setting, or that provide assistance for mobility (i.e., bathing, dressing, eating, grooming, walking, transferring and toileting).

Adult Day Care Services—structured and comprehensive services provided in a group setting that are designed to meet the individual needs of adults with functional impairments. This program provides a variety of health, social and related support services in a protective setting for a portion of a 24-hour day.

Branch—an office from which in-home services such as personal care attendant (PCA), supervised independent living (SIL) and respite are provided within the same DHH region served by the parent agency. The branch office shares administration and supervision.

Client—an individual who is receiving services from a home and community-based service provider.

Department—the Louisiana Department of Health and Hospitals (DHH) or any of its sections, bureaus, offices or its contracted designee.

DHH Region—the geographical administrative regions designated by the Department of Health and Hospitals.

Developmental Disability—a severe, chronic condition as defined in the Developmental Disabilities Law of 2005, R.S. 28:451.l-455.2.

Family Support Services—advocacy services, family counseling, including genetic counseling, family subsidy programs, parent-to-parent outreach, legal assistance, income maintenance, parent training, homemaker services, minor home renovations, marriage and family education, and other related programs.

Geographical Location—the DHH region in which the primary business location of the provider agency operates from.

Health Standards Section—the licensing and certification section of the Department of Health and Hospitals.

Home and Community-Based Service Provider—an agency, institution, society, corporation, person(s) or any other group licensed by the department to provide one or more home and community-based services as defined in R.S. 40:2120.2 or these licensing provisions.

Incident—a death, serious illness, allegation of abuse, neglect or exploitation or an event involving law enforcement or behavioral event which causes serious injury to the client or others.

Individual Service Plan—a service plan developed for each client that is based on a comprehensive assessment which identifies the individual's strengths and needs in order to establish goals and objectives so that outcomes to service delivery can be measured.

Instrumental Activities of Daily Living—the functions or tasks that are not necessary for fundamental functioning but assist an individual to be able to live in a community setting. These are activities such as light house-keeping, food preparation and storage, grocery shopping, laundry, reminders to take medication, scheduling medical appointments, arranging transportation to medical appointments and accompanying the client to medical appointments.

Personal Care Attendant Services—services required for a person with a disability to become physically independent to maintain physical function or to remain in, or return to, the community.

Respite Care—an intermittent service designed to provide temporary relief to unpaid, informal caregivers of the elderly and/or people with disabilities.

Satellite—an alternate location from which center-based respite or adult day care services are provided within the same DHH region served by the parent agency. The branch office shares administration and supervision.

Service Area—the DHH administrative region in which the provider's geographic business location is located and for which the license is issued.

Sub-License—any satellite or branch office operating at a different physical geographic address.

Substitute Family Care Caregiver—a single or dual parent family living in a home setting which has been certified through a home study assessment as adequate and appropriate to provide care to the client by the SFC provider. At least one family member will be designated as a principal SFC caregiver.

Substitute Family Care Services—provide 24-hour personal care, supportive services and supervision to adults who meet the criteria for having a developmental disability.

Supervised Independent Living via a Shared Living Conversion Model—a home and community-based shared living model for up to six persons, chosen by clients of the Residential Options Waiver (ROW), or any successor waiver, as their living option.

Supervised Independent Living Services—necessary training, social skills and medical services to enable a person who has mental illness or a developmental disability, and who is living in congregate, individual homes or individual apartments, to live as independently as possible in the community.

Supported Employment—a system of supports for people with disabilities in regards to ongoing employment in

integrated settings. Supported employment can provide assistance in a variety of areas including:

1. job development;
2. job coaches;
3. job retention;
4. transportation;
5. assistive technology;
6. specialized job training; and
7. individually tailored supervision.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2120.1.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:64 (January 2012).

§5005. Licensure Requirements

A. All HCBS providers shall be licensed by the Department of Health and Hospitals. It shall be unlawful to operate as a home and community-based service provider without a license issued by the department. DHH is the only licensing authority for HCBS providers in Louisiana.

B. An HCBS license shall:

1. be issued only to the person or entity named in the license application;

2. be valid only for the HCBS provider to which it is issued and only for the specific geographic address of that provider, including any sub-license;

3. designate which home and community-based services the provider can provide;

4. enable the provider to render delineated home and community-based services within a DHH region;

5. be valid for one year from the date of issuance, unless revoked, suspended, modified or terminated prior to that date, or unless a provisional license is issued;

6. expire on the last day of the twelfth month after the date of issuance, unless timely renewed by the HCBS provider;

7. not be subject to sale, assignment, donation or other transfer, whether voluntary or involuntary; and

8. be posted in a conspicuous place on the licensed premises at all times.

C. An HCBS provider shall provide only those home and community-based services or modules specified on its license and only to clients residing in the provider's designated service area, DHH Region or at the provider's licensed location.

D. An HCBS provider may apply for a waiver from the Health Standards Section (HSS) to provide services to a client residing outside of the provider's designated service area or DHH Region only under the following condition:

1. A waiver may be granted by the department if there is no other HCBS provider in the client's service area or DHH Region that is licensed and that has the capacity to provide the required services to the client, or for other good cause shown by the HCBS provider and client.

2. The provider must submit a written waiver request to HSS prior to providing services to the client residing outside of the designated service area or DHH Region.

3. The written waiver request shall be specific to one client and shall include the reasons for which the waiver is requested.

E. In order for the HCBS provider to be considered operational and retain licensed status, the provider shall meet the following conditions.

1. Each HCBS provider shall have a business location which shall not be located in an occupied personal residence and shall conform to the provisions of §5027 of this Chapter.

a. The business location shall be part of the licensed location of the HCBS provider and shall be in the DHH Region for which the license is issued.

b. The business location shall have at least one employee on duty at the business location during stated hours of operation.

c. An HCBS provider which provides ADC services or out of home (center-based) respite care services may have the business location at the ADC building or center-based respite building.

2. Adult day care facilities shall have clearly defined days and hours of operation posted. The ADC must be open at least five hours on days of operation. Center-based respite facilities shall have the capacity to provide 24 hour services.

3. There shall be adequate direct care staff and professional services staff employed and available to be assigned to provide services to persons in their homes as per the plan of care. ADC services and center-based respite services should be adequately staffed during the facility's hours of operation.

4. Each HCBS provider shall have at least one published business telephone number. Calls shall be returned within one business day.

F. The licensed HCBS provider shall abide by and adhere to any state law, rule, policy, procedure, manual or memorandum pertaining to HCBS providers.

G. A separately licensed HCBS provider shall not use a name which is substantially the same as the name of another HCBS provider licensed by the department. An HCBS provider shall not use a name which is likely to mislead the client or family into believing it is owned, endorsed or operated by the State of Louisiana.

H. Upon promulgation of the final Rule governing these provisions, existing providers of the following home and community-based services shall be required to apply for an HCBS provider license at the time of renewal of their current license(s):

1. adult day care;
2. family support;
3. personal care attendant;
4. respite;
5. supervised independent living; and
6. supported employment.

I. If an existing provider currently has multiple licenses, such as PCA, respite and SIL, the provider shall be required to apply for an HCBS provider license at the time the first such license is due for renewal. The HCBS provider license shall include all modules for which the provider is currently licensed, and will replace all of the separate licenses.

J. If applicable, each HCBS provider shall obtain facility need review approval prior to licensing.

1. An existing licensed PCA, respite or SIL provider who is applying for an HCBS provider license at the time of license renewal shall not be required to apply for facility need review approval. However, if an existing licensed provider, who is not currently providing PCA, respite or SIL services wants to begin providing these services, the provider shall be required to apply for facility need review approval for each of the requested services.

EXAMPLE: A currently licensed PCA provider with no Respite license is now applying for his HCBS provider license and wants to add the respite module. The PCA provider shall be required to apply for facility need review approval for the respite module.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2120.1.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:65 (January 2012).

§5007. Initial Licensure Application Process

A. An initial application for licensing as an HCBS provider shall be obtained from the department. A completed initial license application packet for an HCBS provider shall be submitted to and approved by the department prior to an applicant providing HCBS services.

B. The initial licensing application packet shall include:

1. a completed HCBS licensure application and the non-refundable licensing fee as established by statute;

2. a copy of the approval letter of the architectural facility plans for the adult day care module and the center-based respite module from the Office of the State Fire Marshal and any other office/entity designated by the department to review and approve the facility's architectural plans;

3. a copy of the on-site inspection report with approval for occupancy by the Office of the State Fire Marshal, if applicable;

4. a copy of the health inspection report with approval of occupancy from the Office of Public Health for the adult day care module and the center-based respite module;

5. a copy of a statewide criminal background check, including sex offender registry status, on all owners and administrators;

6. proof of financial viability, comprised of the following:

a. a line of credit issued from a federally insured, licensed lending institution in the amount of at least $50,000;

b. general and professional liability insurance of at least $300,000; and

c. worker's compensation insurance;

7. a completed disclosure of ownership and control information form;

8. the days and hours of operation;

9. an organizational chart and names, including position titles, of key administrative personnel and governing body; and

10. any other documentation or information required by the department for licensure.

C. Any person convicted of one of the following felonies is prohibited from being the owner or the administrator of an HCBS provider agency. For purposes of these provisions, the licensing application shall be rejected by the department for any felony conviction relating to:

1. the violence, abuse, or negligence of a person;

2. the misappropriation of property belonging to another person;

3. cruelty, exploitation or the sexual battery of the infirmed;

4. a drug offense;

5. crimes of a sexual nature;

6. a firearm or deadly weapon;

7. Medicare or Medicaid fraud; or

8. fraud or misappropriation of federal or state funds.

D. If the initial licensing packet is incomplete, the applicant shall be notified of the missing information and shall have 90 days from receipt of the notification to submit the additional requested information.

1. If the additional requested information is not submitted to the department within 90 days, the application shall be closed.

2. If an initial licensing application is closed, an applicant who is still interested in becoming an HCBS provider must submit a new initial licensing packet with a new initial licensing fee to start the initial licensing process, subject to any facility need review approval.

E. Applicants for HCBS licensure shall be required to attend a mandatory training class when a completed initial licensing application packet has been received by the department.

F. Upon completion of the mandatory training class and written notification of satisfactory class completion from the department, an HCBS applicant shall be required to admit one client and contact the HSS field office to schedule an initial licensing survey.

1. Prior to scheduling the initial survey, applicants must be:

a. fully operational;

b. in compliance with all licensing standards; and

c. providing care to only one client at the time of the initial survey.

2. If the applicant has not admitted one client or called the field office to schedule a survey within 30 days of receipt of the written notification from the department, the application will be closed. If an applicant is still interested in becoming an HCBS provider, a new initial licensing packet with a new initial licensing fee must be submitted to the department to start the initial licensing process, subject to any facility need review approval.

G. Applicants must be in compliance with all appropriate federal, state, departmental or local statutes, laws, ordinances, rules, regulations and fees before the HCBS provider will be issued an initial license to operate.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2120.1.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:66 (January 2012).

§5009. Initial Licensing Surveys

A. Prior to the initial license being issued, an initial on-site licensing survey shall be conducted to ensure compliance with the licensing laws and standards.

B. In the event that the initial licensing survey finds that the HCBS provider is compliant with all licensing laws, regulations and other required statutes, laws, ordinances, rules, regulations, and fees, the department shall issue a full license to the provider. The license shall be valid until the expiration date shown on the license, unless the license is modified, revoked, suspended or terminated.

C. In the event that the initial licensing survey finds that the HCBS provider is noncompliant with any licensing laws or regulations, or any other required rules or regulations that present a potential threat to the health, safety, or welfare of the clients, the department shall deny the initial license.

D. In the event that the initial licensing survey finds that the HCBS provider is noncompliant with any licensing laws

or regulations, or any other required rules or regulations, but the department in its sole discretion determines that the noncompliance does not present a threat to the health, safety or welfare of the clients, the department may issue a provisional initial license for a period not to exceed six months. The provider shall submit a plan of correction to the department for approval, and the provider shall be required to correct all such noncompliance or deficiencies prior to the expiration of the provisional license.

1. If all such noncompliance or deficiencies are corrected on the follow-up survey, a full license will be issued.

2. If all such noncompliance or deficiencies are not corrected on the follow-up survey, or new deficiencies affecting the health, safety or welfare of a client are cited, the provisional license will expire and the provider shall be required to begin the initial licensing process again by submitting a new initial license application packet and the appropriate licensing fee.

E. The initial licensing survey of an HCBS provider shall be an announced survey. Follow-up surveys to the initial licensing surveys are unannounced surveys.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2120.1.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:66 (January 2012).

§5011. Types of Licenses and Expiration Dates

A. The department shall have the authority to issue the following types of licenses:

1. Full Initial License. The department shall issue a full license to the HCBS provider when the initial licensing survey finds that the provider is compliant with all licensing laws and regulations, and is compliant with all other required statutes, laws, ordinances, rules, regulations, and fees. The license shall be valid until the expiration date shown on the license, unless the license is modified, revoked, suspended, or terminated.

2. Provisional Initial License. The department may issue a provisional initial license to the HCBS provider when the initial licensing survey finds that the HCBS provider is noncompliant with any licensing laws or regulations or any other required statutes, laws, ordinances, rules, regulations or fees, but the department determines that the noncompliance does not present a threat to the health, safety or welfare of the clients.

3. Full Renewal License. The department may issue a full renewal license to an existing licensed HCBS provider who is in substantial compliance with all applicable federal, state, departmental, and local statutes, laws, ordinances, rules, regulations and fees. The license shall be valid until the expiration date shown on the license, unless the license is modified, revoked, suspended, or terminated.

B. The department, in its sole discretion, may issue a provisional license to an existing licensed HCBS provider for a period not to exceed six months. The department will consider the following circumstances in making a determination to issue a provisional license:

1. compliance history of the provider to include the scope and severity of deficiencies cited;

2. the number and nature of validated complaints:

a. A validated complaint is a complaint received by the Health Standards Section and found to be substantiated;

3. the existing HCBS provider has been issued a deficiency that involved placing a client at risk for serious harm or death;

4. the existing HCBS provider has failed to correct deficient practices within 60 days of being cited for such deficient practices or at the time of a follow-up survey; or

5. the existing HCBS provider is not in substantial compliance with all applicable federal, state, departmental and local statutes, laws, ordinances, rules regulations and fees at the time of renewal of the license.

C. When the department issues a provisional license to an existing licensed HCBS provider, the provider shall submit a plan of correction to DHH for approval, and the provider shall be required to correct all such noncompliance or deficiencies prior to the expiration of the provisional license. The department shall conduct a follow-up survey, either on-site or by desk review, of the HCBS provider prior to the expiration of the provisional license.

1. If the follow-up survey determines that the HCBS provider has corrected the deficient practices and has maintained compliance during the period of the provisional license, the department may issue a full license for the remainder of the year until the anniversary date of the HCBS license.

2. If the follow-up survey determines that all non-compliance or deficiencies have not been corrected, or if new deficiencies that are a threat to the health, safety or welfare of a client are cited on the follow-up survey, the provisional license shall expire.

3. The department shall issue written notice to the provider of the results of the follow-up survey.

D. If an existing licensed HCBS provider has been issued a notice of license revocation or termination, and the provider's license is due for annual renewal, the department shall deny the license renewal application and shall not issue a renewal license.

1. If a timely administrative appeal has been filed by the provider regarding the license revocation, suspension, or termination, the administrative appeal shall be suspensive, and the provider shall be allowed to continue to operate and provide services until such time as the administrative tribunal or department issues a decision on the license revocation, suspension, or termination.

2. If the secretary of the department determines that the violations of the HCBS provider pose an imminent or immediate threat to the health, welfare, or safety of a client, the imposition of such action may be immediate and may be enforced during the pendency of the administrative appeal. If the secretary of the department makes such a determination, the HCBS provider will be notified in writing.

3. The denial of the license renewal application does not affect in any manner the license revocation, suspension, or termination.

E. The renewal of a license does not in any manner affect any sanction, civil monetary penalty or other action imposed by the department against the provider.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2120.1.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:67 January 2012).

§5013. Changes in Licensee Information or Personnel

A. An HCBS license shall be valid only for the person or entity named in the license application and only for the specific geographic address listed on the license application.

B. Any change regarding the HCBS provider's entity name, "doing business as" name, mailing address, telephone number or any combination thereof, shall be reported in writing to the Health Standards Section within five working days of the change.

C. Any change regarding the HCBS provider's key administrative personnel shall be reported in writing to the Health Standards Section within 10 working days subsequent to the change.

1. Key administrative personnel include the:
   a. administrator;
   b. director of nursing, if applicable; and
   c. medical director, if applicable.

2. The HCBS provider's notice to the department shall include the individual's:
   a. name;
   b. address;
   c. hire date; and
   d. qualifications.

D. A change of ownership (CHOW) of the HCBS provider shall be reported in writing to the department within five working days subsequent to the change. The license of an HCBS provider is not transferable or assignable and cannot be sold. The new owner shall submit the legal CHOW document, all documents required for a new license and the applicable licensing fee. Once all application requirements are completed and approved by the department, a new license shall be issued to the new owner.

1. An HCBS provider that is under license revocation may not undergo a CHOW.

2. If the CHOW results in a change of geographic address, an on-site survey may be required prior to issuance of the new license.

E. If the HCBS provider changes its name without a change in ownership, the HCBS provider shall report such change to the department in writing five days prior to the change. The change in the HCBS provider name requires a change in the HCBS provider license. Payment of the applicable fee is required to re-issue the license.

F. Any request for a duplicate license shall be accompanied by the applicable fee.

G. If the HCBS provider changes the physical address of its geographic location without a change in ownership, the HCBS provider shall report such change to DHH in writing at least five days prior to the change. Because the license of an HCBS provider is valid only for the geographic location of that provider, and is not transferrable or assignable, the provider shall submit a new licensing application.

1. An on-site survey may be required prior to the issuance of the new license.

2. The change in the HCBS provider's physical address results in a new anniversary date and the full licensing fee must be paid.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2120.1.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:68 (January 2012).

§5015. Renewal of License

A. The HCBS provider shall submit a completed license renewal application packet to the department at least 30 days prior to the expiration of the current license. The license renewal application packet shall include:

1. the license renewal application;
2. the days and hours of operation;
3. a current State Fire Marshal report, if applicable;
4. a current Office of Public Health inspection report for the adult day care module and the center-based respite module;
5. the non-refundable license renewal fee;
6. any other documentation required by the department; and
7. proof of financial viability, comprised of the following:
   a. a line of credit issued from a federally insured, licensed lending institution in the amount of at least $50,000;
   b. general and professional liability insurance of at least $300,000; and
   c. worker's compensation insurance.

B. The department may perform an on-site survey and inspection upon annual renewal of a license.

C. Failure to submit a completed license renewal application packet prior to the expiration of the current license will result in the voluntary non-renewal of the HCBS license.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2120.1.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:68 (January 2012).

§5016. Deemed Status through Accreditation

A. An HCBS provider may request deemed status from the department. The department may accept accreditation in lieu of a routine on-site resurvey provided that:

1. the accreditation is obtained through an organization approved by the department;
2. all services provided under the HCBS license must be accredited; and
3. the provider forwards the accrediting body's findings to the Health Standards Section within 30 days of its accreditation.

B. The accreditation will be accepted as evidence of satisfactory compliance with all provisions of these requirements.

C. The following set of circumstances can cause the state agency to perform a full licensing survey on an accredited HCBS provider:

1. any valid complaints in the preceding 12-month period;
2. addition of services;
3. a change of ownership in the preceding 12-month period;
4. issuance of a provisions license in the preceding 12-month period;

5. serious violations of licensing standards or professional standards of practice that were identified in the preceding 12-month period; or

6. reports of inappropriate treatment or service resulting in death or serious injury.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2120.1.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:68 (January 2012).

§5017. Survey Activities

A. The department, or its designee, may conduct periodic licensing surveys and other surveys as deemed necessary to ensure compliance with all laws, rules and regulations governing HCBS providers and to ensure client health, safety and welfare. These surveys may be conducted on-site or by administrative review and shall be unannounced.

B. The department shall also conduct complaint surveys. The complaint surveys shall be conducted in accordance with R.S. 40:2009.13 et seq.

C. The department shall require an acceptable plan of correction from a provider for any survey where deficiencies have been cited, regardless of whether the department takes other action against the facility for the deficiencies cited in the survey. The acceptable plan of correction shall be approved by the department.

D. A follow-up survey may be conducted for any survey where deficiencies have been cited to ensure correction of the deficient practices.

E. The department may issue appropriate sanctions for noncompliance, deficiencies and violations of law, rules and regulations. Sanctions include, but are not limited to:

1. civil monetary penalties;
2. directed plans of correction; and
3. license revocation.

F. DHH surveyors and staff shall be:

1. given access to all areas of the provider agency, as necessary, and all relevant files during any survey; and

2. allowed to interview any provider staff, client or other persons as necessary or required to conduct the survey.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2120.1.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:69 (January 2012).

§5019. Statement of Deficiencies

A. The following statements of deficiencies issued by the department to the HCBS provider shall be posted in a conspicuous place on the licensed premises:

1. the most recent annual survey statement of deficiencies; and

2. any subsequent complaint survey statement of deficiencies.

B. Any statement of deficiencies issued by the department to an HCBS provider shall be available for disclosure to the public 30 days after the provider submits an acceptable plan of correction to the deficiencies or 90 days after the statement of deficiencies is issued to the provider, whichever occurs first.

C. Unless otherwise provided in statute or in these licensing provisions, a provider shall have the right to an informal reconsideration of any deficiencies cited as a result of a survey or investigation.

1. Correction of the violation, noncompliance or deficiency shall not be the basis for the reconsideration.

2. The informal reconsideration of the deficiencies shall be requested in writing within 10 days of receipt of the statement of deficiencies, unless otherwise provided in these standards.

3. The request for informal reconsideration of the deficiencies shall be made to the department's Health Standards Section and will be considered timely if received by HSS within 10 days of the provider's receipt of the statement deficiencies.

4. If a timely request for an informal reconsideration is received, the department shall schedule and conduct the informal reconsideration.

5. The provider shall be notified in writing of the results of the informal reconsideration.

6. Except as provided for complaint surveys pursuant to R.S. 40:2009.13 et seq., and as provided in these licensing provisions for license denials, revocations and non-renewals, the decision of the informal reconsideration team shall be the final administrative decision regarding the deficiencies.

a. There is no administrative appeal right of such deficiencies.

7. Pursuant to R.S. 40:2009.13 et seq., for complaint surveys in which the Health Standards Section determines that the complaint involves issues that have resulted in or are likely to result in serious harm or death, as defined in the statute, the determination of the informal reconsideration may be appealed administratively to the Division of Administrative Law or its successor. The hearing before the Division of Administrative Law, or its successor, is limited only to whether the investigation or complaint survey was conducted properly or improperly. The Division of Administrative Law shall not delete or remove deficiencies as a result of such hearing.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2120.1.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:69 (January 2012).

§5021. Denial of License, Revocation of License, Denial of License Renewal

A. The department may deny an application for an initial license or a license renewal, or may revoke a license in accordance with the provisions of the Administrative Procedure Act. These actions may be taken against the entire license or certain modules of the license.

B. Denial of an Initial License

1. The department shall deny an initial license in the event that the initial licensing survey finds that the HCBS provider is noncompliant with any licensing laws or regulations, or any other required statutes or regulations that present a potential threat to the health, safety or welfare of the clients.

2. The department shall deny an initial license for any of the reasons a license may be revoked or non-renewed pursuant to these licensing provisions.

3. If the department denies an initial license, the applicant for an HCBS provider license shall discharge the client receiving services.

C. Voluntary Non-Renewal of a License. If a provider fails to timely renew its license, the license expires on its

face and is considered voluntarily surrendered. There are no appeal rights for such surrender or non-renewal of the license, as this is a voluntary action on the part of the provider.

D. Revocation of License or Denial of License Renewal. An HCBS provider license may be revoked or denied renewal for any of the following reasons, including but not limited to:

1. failure to be in substantial compliance with the HCBS licensing laws, rules and regulations;

2. failure to be in substantial compliance with other required statutes, laws, ordinances, rules or regulations;

3. failure to comply with the terms and provisions of a settlement agreement or education letter;

4. failure to uphold client rights whereby deficient practices result in harm, injury or death of a client;

5. failure to protect a client from a harmful act of an employee or other client including, but not limited to:

a. mental or physical abuse, neglect, exploitation or extortion;

b. any action posing a threat to a client's health and safety;

c. coercion;

d. threat or intimidation;

e. harassment; or

f. criminal activity;

6. failure to notify the proper authorities, as required by federal or state law or regulations, of all suspected cases of the acts outlined in §5021.D.5;

7. knowingly making a false statement in any of the following areas, including but not limited to:

a. application for initial license or renewal of license;

b. data forms;

c. clinical records, client records or provider records;

d. matters under investigation by the department or the Office of the Attorney General; or

e. information submitted for reimbursement from any payment source;

8. knowingly making a false statement or providing false, forged or altered information or documentation to DHH employees or to law enforcement agencies;

9. the use of false, fraudulent or misleading advertising; or

10. an owner, officer, member, manager, administrator, director or person designated to manage or supervise client care has pled guilty or nolo contendere to a felony, or has been convicted of a felony, as documented by a certified copy of the record of the court;

a. For purposes of these provisions, conviction of a felony involves any felony conviction relating to:

i. the violence, abuse, or negligence of a person;

ii. the misappropriation of property belonging to another person;

iii. cruelty, exploitation or the sexual battery of the infirmed;

iv. a drug offense;

v. crimes of a sexual nature;

vi. a firearm or deadly weapon;

vii. Medicare or Medicaid fraud; or

viii. fraud or misappropriation of federal or state funds;

11. failure to comply with all reporting requirements in a timely manner, as required by the department;

12. failure to allow or refusal to allow the department to conduct an investigation or survey or to interview provider staff or clients;

13. interference with the survey process, including but not limited to, harassment, intimidation, or threats against the survey staff;

14. failure to allow or refusal to allow access to provider, facility or client records by authorized departmental personnel;

15. bribery, harassment, intimidation or solicitation of any client designed to cause that client to use or retain the services of any particular HCBS provider;

16. cessation of business or non-operational status;

17. failure to repay an identified overpayment to the department or failure to enter into a payment agreement to repay such overpayment; or

18. failure to timely pay outstanding fees, fines, sanctions or other debts owed to the department.

E. In the event an HCBS provider license is revoked, renewal is denied (other than for cessation of business or non-operational status) or the license is surrendered in lieu of an adverse action, any owner, board member, director or administrator, and any other person named on the license application of such HCBS provider is prohibited from owning, managing, directing or operating another HCBS agency for a period of two years from the date of the final disposition of the revocation, denial action or surrender.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2120.1.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:69 (January 2012).

§5023. Notice and Appeal of License Denial, License Revocation and License Non-Renewal

A. Notice of a license denial, license revocation or license non-renewal (i.e. denial of license renewal) shall be given to the provider in writing.

B. The HCBS provider has a right to an informal reconsideration of the license denial, license revocation or license non-renewal. There is no right to an informal reconsideration of a voluntary non-renewal or surrender of a license by the provider.

1. The HCBS provider shall request the informal reconsideration within 15 days of the receipt of the notice of the license denial, license revocation or license non-renewal. The request for informal reconsideration shall be in writing and shall be forwarded to the department's Health Standards Section. The request for informal reconsideration shall be considered timely if received by the Health Standards Section within 15 days from the provider's receipt of the notice.

2. The request for informal reconsideration shall include any documentation that demonstrates that the determination was made in error.

3. If a timely request for an informal reconsideration is received by HSS, an informal reconsideration shall be scheduled and the provider will receive written notification of the date of the informal reconsideration.

4. The provider shall have the right to appear in person at the informal reconsideration and may be represented by counsel.

5. Correction of a violation or deficiency which is the basis for the license denial, revocation or non-renewal shall not be a basis for reconsideration.

6. The informal reconsideration process is not in lieu of the administrative appeals process.

7. The provider will be notified in writing of the results of the informal reconsideration.

C. The HCBS provider has a right to an administrative appeal of the license denial, license revocation or license non-renewal. There is no right to an administrative appeal of a voluntary non-renewal or surrender of a license by the provider.

1. The HCBS provider shall request the administrative appeal within 30 days of the receipt of the results of the informal reconsideration.

a. The HCBS provider may forego its rights to an informal reconsideration, and if so, shall request the administrative appeal within 30 calendar days of the receipt of the notice of the license denial, revocation or non-renewal.

2. The request for administrative appeal shall be in writing and shall be submitted to the Division of Administrative Law, or its successor. The request shall include any documentation that demonstrates that the determination was made in error and shall include the basis and specific reasons for the appeal.

3. If a timely request for an administrative appeal is received by the Division of Administrative Law, or its successor, the administrative appeal of the license revocation or license non-renewal shall be suspensive, and the provider shall be allowed to continue to operate and provide services until such time as the department issues a final administrative decision.

a. If the secretary of the department determines that the violations of the provider pose an imminent or immediate threat to the health, welfare or safety of a client, the imposition of the license revocation or license non-renewal may be immediate and may be enforced during the pendency of the administrative appeal. If the secretary of the department makes such a determination, the provider will be notified in writing.

4. Correction of a violation or a deficiency which is the basis for the denial, revocation or non-renewal shall not be a basis for an administrative appeal.

D. If an existing licensed HCBS provider has been issued a notice of license revocation, and the provider's license is due for annual renewal, the department shall deny the license renewal application. The denial of the license renewal application does not affect, in any manner, the license revocation.

E. If a timely administrative appeal has been filed by the provider on a license denial, license non-renewal or license revocation, the Division of Administrative Law, or its successor, shall conduct the hearing within 90 calendar days of the docketing of the administrative appeal. One extension, not to exceed 90 days, may be granted by the Division of Administrative Law, or its successor, if good cause is shown.

1. If the final agency decision is to reverse the license denial, license non-renewal or license revocation, the provider's license will be re-instated or granted upon the payment of any licensing fees, outstanding sanctions or other fees due to the department.

2. If the final agency decision is to affirm the license non-renewal or license revocation, the provider shall discharge any and all clients receiving services according to the provisions of this Chapter.

a. Within 10 calendar days of the final agency decision, the provider must notify HSS, in writing, of the secure and confidential location where the client records will be stored.

F. There is no right to an informal reconsideration or an administrative appeal of the issuance of a provisional initial license to a new HCBS provider, or the issuance of a provisional license to an existing HCBS provider. A provider who has been issued a provisional license is licensed and operational for the term of the provisional license. The issuance of a provisional license is not considered to be a denial of license, renewal or revocation.

G. A provider with a provisional initial license or an existing provider with a provisional license that expires due to noncompliance or deficiencies cited at the follow-up survey, shall have the right to an informal reconsideration and the right to an administrative appeal, as to the deficiencies.

1. The correction of a violation, noncompliance or deficiency after the follow-up survey shall not be the basis for the informal reconsideration or for the administrative appeal.

2. The informal reconsideration and the administrative appeal are limited to whether the deficiencies were properly cited at the follow-up survey.

3. The provider shall request the informal reconsideration in writing, which shall be received by the Health Standards Section within five days of receipt of the notice of the results of the follow-up survey from the department.

4. The provider shall request the administrative appeal within 15 days of receipt of the notice of the results of the follow-up survey from the department. The request for administrative appeal shall be in writing and shall be submitted to the Division of Administrative Law, or its successor.

5. A provider with a provisional initial license or an existing provider with a provisional license that expires under the provisions of this Chapter shall cease providing services and discharge clients unless the Division of Administrative Law, or its successor, issues a stay of the expiration.

a. The stay may be granted by the Division of Administrative Law, or its successor, upon application by the provider at the time the administrative appeal is filed and only after a contradictory hearing and only upon a showing that there is no potential harm to the clients being served by the provider.

6. If a timely administrative appeal has been filed by a provider with a provisional initial license that has expired, or by an existing provider whose provisional license has expired under the provisions of this Chapter, the Division of Administrative Law, or its successor, shall conduct the hearing within 90 calendar days of the docketing of the administrative appeal. One extension, not to exceed 90 days,

may be granted by the Division of Administrative Law, or its successor, if good cause is shown.

a. If the final agency decision is to remove all deficiencies, the provider's license will be re-instated upon the payment of any outstanding sanctions and licensing or other fees due to the department.

b. If the final agency decision is to uphold the deficiencies and affirm the expiration of the provisional license, the provider shall discharge any and all clients receiving services.

i. Within 10 calendar days of the final agency decision, the provider must notify HSS in writing of the secure and confidential location where the client records will be stored.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2120.1.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:70 (January 2012).

§5025. Inactivation of License due to a Declared Disaster or Emergency

A. An HCBS provider licensed in a parish which is the subject of an executive order or proclamation of emergency or disaster issued in accordance with R.S. 29:724 or R.S. 29:766, may seek to inactivate its license for a period not to exceed one year, provided that the following conditions are met:

1. the licensed provider shall submit written notification to the Health Standards Section within 60 days of the date of the executive order or proclamation of emergency or disaster that:

a. the HCBS provider has experienced an interruption in the provisions of services as a result of events that are the subject of such executive order or proclamation of emergency or disaster issued in accordance with R.S. 29:724 or R.S. 29:766;

b. the licensed HCBS provider intends to resume operation as an HCBS provider in the same service area;

c. includes an attestation that the emergency or disaster is the sole casual factor in the interruption of the provision of services;

d. includes an attestation that all clients have been properly discharged or transferred to another provider; and

e. provides a list of each client and where that client is discharged or transferred to;

2. the licensed HCBS provider resumes operating as a HCBS provider in the same service area within one year of the issuance of an executive order or proclamation of emergency or disaster in accordance with R.S. 29:724 or R.S. 29:766;

3. the licensed HCBS provider continues to pay all fees and cost due and owed to the department including, but not limited to, annual licensing fees and outstanding civil monetary penalties; and

4. the licensed HCBS provider continues to submit required documentation and information to the department.

B. Upon receiving a completed written request to inactivate a HCBS provider license, the department shall issue a notice of inactivation of license to the HCBS provider.

C. Upon completion of repairs, renovations, rebuilding or replacement, an HCBS provider which has received a notice of inactivation of its license from the department shall be allowed to reinstate its license upon the following conditions being met.

1. The HCBS provider shall submit a written license reinstatement request to the licensing agency of the department 60 days prior to the anticipated date of reopening.

a. The license reinstatement request shall inform the department of the anticipated date of opening, and shall request scheduling of a licensing survey.

b. The license reinstatement request shall include a completed licensing application with appropriate licensing fees.

2. The provider resumes operating as an HCBS provider in the same service area within one year.

D. Upon receiving a completed written request to reinstate an HCBS provider license, the department shall conduct a licensing survey. If the HCBS provider meets the requirements for licensure and the requirements under this Section, the department shall issue a notice of reinstatement of the HCBS provider license.

1. The licensed capacity of the reinstated license shall not exceed the licensed capacity of the HCBS provider at the time of the request to inactivate the license.

E. No change of ownership in the HCBS provider shall occur until such HCBS provider has completed repairs, renovations, rebuilding or replacement construction, and has resumed operations as an HCBS provider.

F. The provisions of this Section shall not apply to an HCBS provider which has voluntarily surrendered its license and ceased operation.

G. Failure to comply with any of the provisions of this Section shall be deemed a voluntary surrender of the HCBS provider license and any applicable facility need review approval for licensure.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2120.1.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:72 (January 2012).

Subchapter B. Administration and Organization

§5027. Governing Body

A. An HCBS provider shall have an identifiable governing body with responsibility for and authority over the policies and activities of the program/agency.

1. A provider shall have documents identifying all members of the governing body, their addresses, their terms of membership, officers of the governing body and terms of office of any officers.

2. The governing body shall be comprised of three or more persons and shall hold formal meetings at least twice a year.

3. There shall be written minutes of all formal meetings of the governing body and by-laws specifying frequency of meetings and quorum requirements.

B. The governing body of an HCBS provider shall:

1. ensure the provider's continual compliance and conformity with all relevant federal, state, local and municipal laws and regulations;

2. ensure that the provider is adequately funded and fiscally sound;

3. review and approve the provider's annual budget;

4. designate a person to act as administrator and delegate sufficient authority to this person to manage the provider agency;

5. formulate and annually review, in consultation with the administrator, written policies concerning the provider's philosophy, goals, current services, personnel practices, job descriptions and fiscal management;

6. annually evaluate the administrator's performance;

7. have the authority to dismiss the administrator;

8. meet with designated representatives of the department whenever required to do so;

9. inform Health Standards prior to initiating any substantial changes in the nature and scope of services provided by the provider; and

10. ensure statewide criminal background checks on all unlicensed persons providing direct care and services to clients in accordance with R.S. 40:1300.52 or other applicable state law; and

11. ensure that direct support staff comply with R.S. 40:1300.52 or other applicable state law.

C. An HCBS provider shall maintain an administrative file that includes:

1. documents identifying the governing body;

2. a list of members and officers of the governing body, along with their addresses and terms of membership;

3. minutes of formal meetings and by-laws of the governing body, if applicable;

4. a copy of the current license issued by Health Standards;

5. an organizational chart of the provider which clearly delineates the line of authority;

6. all leases, contracts and purchases-of-service agreements to which the provider is a party;

7. insurance policies;

8. annual budgets and audit reports; and

9. a master list of all the community resources used by the provider.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2120.1.

HISTORY NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:72 (January 2012).

§5029. Policy and Procedures

A. An HCBS provider shall provide supervision and services that:

1. conform to the department's rules and regulations;

2. meet the needs of the clients as identified and addressed in the ISP;

3. provide for the full protection of clients' rights; and

4. promote the social, physical and mental well-being of clients;

B. An HCBS provider shall make any required information or records, and any information reasonably related to assessment of compliance with these requirements, available to the department.

C. An HCBS provider shall allow designated representatives of the department, in performance of their mandated duties, to:

1. inspect all aspects of an HCBS provider's operations which directly or indirectly impact clients; and

2. conduct interviews with any staff member or client of the provider.

D. An HCBS provider shall, upon request by the department, make available the legal ownership documents.

E. The HCBS provider shall have written policies and procedures approved by the owner or governing body, which must be implemented and followed, that address at a minimum the following:

1. confidentiality and confidentiality agreements;

2. security of files;

3. publicity and marketing, including the prohibition of illegal or coercive inducement, solicitation and kickbacks;

4. personnel;

5. client rights;

6. grievance procedures;

7. client funds;

8. emergency preparedness;

9. abuse and neglect;

10. incidents and accidents, including medical emergencies;

11. universal precautions;

12. documentation; and

13. admission and discharge procedures.

F. An HCBS provider shall have written personnel policies, which must be implemented and followed, that include:

1. a plan for recruitment, screening, orientation, ongoing training, development, supervision and performance evaluation of staff members;

2. written job descriptions for each staff position, including volunteers;

3. policies that shall, at a minimum, be consistent with Office of Public Health guidelines to indicate whether, when, and how staff have a health assessment;

4. an employee grievance procedure;

5. abuse reporting procedures that require all employees to report any incidents of abuse or mistreatment, whether that abuse or mistreatment is done by another staff member, a family member, a client or any other person; and

6. a written policy to prevent discrimination.

G. An HCBS provider shall maintain, in force at all times, the requirements for financial viability under this rule.

H. The provider shall have written policies and procedures for behavior management which:

1. prohibits:

a. corporeal punishment;

b. chemical restraints;

c. psychological and verbal abuse;

d. seclusion;

e. forced exercise;

f. physical and mechanical restraints;

f. any cruel, severe, unusual, degrading or unnecessary punishment; and

g. any procedure which denies:

i. food;

ii. drink;

iii. visits with family; or

iv. use of restroom facilities;

2. ensure that non-intrusive positive approaches to address the meaning/origins of behaviors are used prior to the development of a restrictive plan; and

3. cover any behavioral emergency and provide documentation of the event in an incident report format.

I. An HCBS provider shall comply with all federal and state laws, rules and regulations in the development and implementation of its policies and procedures.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2120.1.

HISTORY NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:73 (January 2012).

§5031. Business Location

A. All HCBS providers shall have a business location in the DHH Region for which the license is issued. The business location shall be a part of the physical geographic licensed location and shall be where the provider:

1. maintains staff to perform administrative functions;
2. maintains the provider's personnel records;
3. maintains the provider's client service records; and
4. holds itself out to the public as being a location for receipt of client referrals.

B. The business location shall have a separate entrance and exit from any other entity, business or trade, and shall have appropriate signage indicating the legal or trade name and address of the health care provider. The HCBS provider shall operate independently from any other business or entity, and shall not operate office space with any other business or entity.

1. The HCBS provider may share common areas with another business or entity. Common areas include foyers, kitchens, conference rooms, hallways, stairs, elevators or escalators when used to provide access to the provider's separate entrance.

2. Records or other confidential information shall not be stored in areas deemed to be common areas.

C. The business location shall:

1. be commercial office space or, if located in a residential area, be zoned for appropriate commercial use and shall be used solely for the operation of the business;

a. the business location may not be located in an occupied personal residence;

2. have approval from the Louisiana Office of the State Fire Marshal;

3. have a published telephone number which is available and accessible 24 hours a day, seven days a week, including holidays;

4. have a business fax number that is operational 24 hours a day, seven days a week;

5. have internet access and a working e-mail address;

a. the e-mail address shall be provided to the department;

6. have hours of operation posted in a location outside of the business that is easily visible to persons receiving services and the general public; and

7. have space for storage of client records in an area that is secure and does not breach confidentiality of personal health information.

D. Branch Offices and Satellites of HCBS Providers

1. An HCBS provider who currently provides in-home services such as PCA, respite or SIL services may apply to the department for approval to operate a branch office to provide those same services. The branch office falls under the license of the parent agency and shall be located in the same DHH Region as the parent agency.

2. An HCBS provider who currently provides ADC services or provides center-based respite services may apply to the department for approval to operate a satellite location to provide additional ADC services or center-based respite services at that satellite location. The satellite location falls under the license of the parent agency and shall be located in the same DHH Region as the parent agency.

3. No branch office or satellite location may be opened without written approval from the department. In order for a branch office or satellite location to be approved, the parent agency must have full licensure for at least one year. Branch office approvals and satellite location approvals will be renewed at the time of renewal of the parent agency's license, if the parent agency meets the requirements for licensure.

4. The department will consider the following in making a determination whether to approve a branch office or a satellite location:

a. compliance history of the provider to include the scope and severity of deficiencies cited within the last 12 months;

b. the number and nature of validated complaints within the last 12 months;

c. the parent agency has a provisional license;

d. the parent agency is under license revocation;

e. the parent agency is undergoing a change of ownership; or

f. adverse action, including license revocation, denial or suspension, has been taken against the license of other agencies operated by the owner of the parent agency.

5. The branch office or satellite location shall be held out to the public as a branch, division, or satellite of the parent agency so that the public will be aware of the identity of the agency operating the branch or satellite.

a. Reference to the name of the parent agency shall be contained in any written documents, signs or other promotional materials relating to the branch or satellite.

6. Original personnel files shall not be maintained at the branch office or satellite location.

7. A branch office or a satellite location is subject to survey, including complaint surveys, by the department at any time to determine compliance with minimum licensing standards.

8. A branch office or a satellite location shall:

a. serve as part of the geographic service area approved for the parent agency;

b. retain an original or duplicate copy of all clinical records for its clients for a 12 month period. Duplicate records need not be maintained at the parent agency, but shall be made available to state surveyors during any survey upon request within a reasonable amount of time;

c. maintain a statement of personnel policies on-site for staff usage;

d. post and maintain regular office hours; and

e. staff the branch office or satellite location during regular office hours.

9. Each branch office shall be assessed a fee of $200, assessed at the time the license application is made for the branch and once a year thereafter for renewal of the branch license. This fee is non-refundable and is in addition to any other fees that may be assessed according to the laws, rules, regulations and standards.

10. Each satellite location shall be assessed a fee of $250, assessed at the time the license application is made for the satellite location and once a year thereafter for renewal of the satellite location license. This fee is non-refundable and is in addition to any other fees that may be assessed according to the laws, rules, regulations and standards.

11. The department at its sole discretion, and taking into consideration resources of the department, may approve branch offices for HCBS providers rending in-home services.

12. The department at its sole discretion, and taking into consideration resources of the department, may approve satellite locations for HCBS providers rendering center-based respite or adult day care services.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2120.1.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:74 (January 2012).

Subchapter C. Admission, Transfer and Discharge Criteria

§5033. Admissions

A. An HCBS provider shall have written admissions policies and criteria which shall include the following:

1. intake policy and procedures;
2. admission criteria and procedures;
3. admission criteria and procedures for minors;
4. policy regarding the determination of legal status, according to appropriate state laws, before admission;
5. the age of the populations served;
6. the services provided by the provider's program(s); and
7. criteria for discharge.

B. The written description of admissions policies and criteria shall be provided to the department upon request, and made available to the client and his/her legal representative.

C. An HCBS provider shall ensure that the client, the legal representative, where appropriate, or other persons are provided an opportunity to participate in the admission process and decisions.

1. Proper consents shall be obtained before admission.
2. Where such involvement of the client is not possible or not desirable, the reasons for their exclusion shall be recorded.

D. An HCBS provider shall not refuse admission to any client on the grounds of race, national origin, ethnicity or disability.

E. An HCBS provider shall meet the needs of each client admitted to his/her program as identified and addressed in the client's ISP.

F. When refusing admission, a provider shall provide a written statement as to the reason for the refusal. This shall be provided to designated representatives of the department or to a client upon request.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2120.1.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:75 (January 2012).

§5035. Voluntary Transfers and Discharges

A. A client has the right to choose a provider. This right includes the right to be discharged from his current provider, be transferred to another provider and to discontinue services altogether.

B. Upon notice by the client or authorized representative that the client has selected another provider or has decided to discontinue services or moves from the geographical region serviced by the provider, the HCBS provider shall have the responsibility of planning for a client's voluntary transfer or discharge.

C. The transfer or discharge responsibilities of the HCBS provider shall include:

1. holding a transfer or discharge planning conference with the client, family, support coordinator, legal representative and advocate, if such are known, in order to facilitate a smooth transfer or discharge, unless the client declines such a meeting;
2. providing a current individual service plan (ISP). Upon written request and authorization by the client or authorized representative, a copy of the current ISP shall be provided to the client or receiving provider; and
3. preparing a written discharge summary. The discharge summary shall include, at a minimum, a summary on the health, developmental issues, behavioral issues, social issues, and nutritional status of the client. Upon written request and authorization by the client or authorized representative, a copy of the discharge summary shall be disclosed to the client or receiving provider.

D. The written discharge summary shall be completed within five working days of the notice by the client or authorized representative that the client has selected another provider or has decided to discontinue services.

1. The provider's preparation of the discharge summary shall not impede or impair the client's right to be transferred or discharged immediately if the client so chooses.

E. The provider shall not coerce the client to stay with the provider agency or interfere in any way with the client's decision to transfer. Failure to cooperate with the client's decision to transfer to another provider will result in adverse action by the department.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2120.1.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:75 (January 2012).

§5037. Involuntary Transfers and Discharges

A. An HCBS provider shall not transfer or discharge the client from the provider except under the following circumstances. These situations will be considered involuntary transfers or discharges.

1. The client's health has improved sufficiently so that the client no longer needs the services rendered by the provider.
2. The safety or health of a client(s) or provider staff is endangered.
3. The client has failed to pay any past due amounts for services for which he/she is liable within 15 days after receipt of written notice from the provider.
4. The provider ceases to operate.
5. The client or family refuses to cooperate or interferes with attaining the objectives of the HCBS provider.
6. The HCBS provider closes a particular module so that certain services are no longer provided.

B. When the provider proposes to involuntarily transfer or discharge a client, compliance with the provisions of this Section shall be fully documented in the client's records.

C. An HCBS provider shall provide a written notice of the involuntary transfer or discharge to the client, a family member of the client, if known, to the authorized representative if known, and the support coordinator if applicable, at least 30 calendar days prior to the transfer or discharge.

1. The written notice shall be sent via certified mail, return receipt requested.

2. When the safety or health of clients or provider staff is endangered, written notice shall be given as soon as practicable before the transfer or discharge.

3. When the client has failed to pay any outstanding amounts for services for which he is liable, written notice may be given immediately. Payment is due within 15 days of receipt of written notice from the provider that an amount is due and owing.

4. The notice of involuntary discharge or transfer shall be in writing and in a language and manner that the client understands.

5. A copy of the notice of involuntary discharge or transfer shall be placed in the client's clinical record.

D. The written notice of involuntary transfer or discharge shall include:

1. a reason for the transfer or discharge;

2. the effective date of the transfer or discharge;

3. an explanation of a client's right to personal and/or third party representation at all stages of the transfer or discharge process;

4. contact information for the Advocacy Center;

5. names of provider personnel available to assist the client and family in decision making and transfer arrangements;

6. the date, time and place for the discharge planning conference;

7. a statement regarding the client's appeal rights;

8. the name of the director, current address and telephone number of the Division of Administrative Law, or its successor; and

9. a statement regarding the client's right to remain with the provider and not be transferred or discharged if an appeal is timely filed.

E. Appeal Rights for Involuntary Transfers or Discharges

1. If a timely appeal is filed by the client or authorized representative disputing the involuntary discharge, the provider shall not transfer or discharge the client pursuant to the provisions of this Section.

NOTE: The provider's failure to comply with these requirements may result in revocation of a provider's license.

2. If nonpayment is the basis of the involuntary transfer or discharge, the client shall have the right to pay the balance owed to the provider up to the date of the transfer or discharge and is then entitled to remain with the agency if outstanding balances are paid.

3. If a client files a timely appeal request, the Division of Administrative Law, or its successor, shall hold an appeal hearing at the agency or by telephone, if agreed upon by the appellant, within 30 days from the date the appeal is filed with the Division of Administrative Law, or its successor,.

a. If the basis of the involuntary discharge is due to endangerment of the health or safety of the staff or individuals, the provider may make a written request to the Division of Administrative Law, or its successor, to hold a pre-hearing conference.

i. If a pre-hearing conference request is received by the Division of Administrative Law, or its successor, the pre-hearing conference shall be held within 10 days of receipt of the written request from the provider.

4. The Division of Administrative Law, or its successor, shall issue a decision within 30 days from the date of the appeal hearing.

5. The burden of proof is on the provider to show, by a preponderance of the evidence, that the transfer or discharge of the client is justified pursuant to the provisions of the minimum licensing standards.

F. Client's Right to Remain with the Provider Pending the Appeal Process

1. If a client is given 30 calendar days written notice of the involuntary transfer or discharge and the client or authorized representative files a timely appeal, the client may remain with the provider and not be transferred or discharged until the Division of Administrative Law, or its successor, renders a decision on the appeal.

2. If a client is given less than 30 calendar days written notice and files a timely appeal of an involuntary transfer/discharge based on the health and safety of individuals or provider staff being endangered, the client may remain with the provider and not be transferred or discharged until one of the following occurs:

a. the Division of Administrative Law, or its successor, holds a pre-hearing conference regarding the safety or health of the staff or individuals; or

b. the Division of Administrative Law, or its successor, renders a decision on the appeal.

3. If a client is given less than 30 calendar days written notice and files a timely appeal of an involuntary transfer/discharge based on the client's failure to pay any outstanding amounts for services within the allotted time, the provider may discharge or transfer the client.

G. The transfer or discharge responsibilities of the HCBS provider shall include:

1. holding a transfer or discharge planning conference with the client, family, support coordinator, legal representative and advocate, if such are known, in order to facilitate a smooth transfer or discharge;

2. development of discharge options that will provide reasonable assurance that the client will be transferred or discharged to a setting that can be expected to meet his/her needs;

2. preparing an updated ISP; and

3. preparing a written discharge summary. The discharge summary shall include, at a minimum, a summary of the health, developmental issues, behavioral issues, social issues and nutritional status of the client. Upon written request and authorization by the client or authorized representative, a copy of the discharge summary and/or updated ISP shall be disclosed to the client or receiving provider.

H. The agency shall provide all services required prior to discharge that are contained in the final update of the individual service plan and in the transfer or discharge plan.

1. The provider shall not be required to provide services if the discharge is due to the client moving out of the provider's geographical region. An HCBS provider is prohibited from providing services outside of its geographical region without the Department's approval.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2120.1.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:75 (January 2012).

Subchapter D. Service Delivery

§5039. General Provisions

A. The HCBS provider shall ensure that the client receives the necessary care and services to attain or maintain the highest practicable physical, mental and psychosocial well-being of the client, in accordance with the comprehensive assessment and individual service plan.

B. All services provided to the client shall be provided in accordance with an individual service plan.

C. Assessment of Needs

1. Prior to any service being rendered, an HCBS provider shall conduct an assessment of the client's needs. The assessment shall include, at a minimum:

a. risk assessment, including:

i. life safety (i.e. the ability to access emergency services, basic safety practices and evaluation of the living unit);

ii. home environment;

iii. environmental risk; and

iv. medical risk;

b. medical assessments, including:

i. diagnosis;

ii. medications, including methods of administration; and

iii. current services and treatment regimen;

c. activities of daily living;

d. instrumental activities of daily living including money management, if applicable;

e. communication skills;

f. social skills; and

g. psychosocial skills including behavioral needs.

2. If medical issues are identified in the assessment, a licensed physician or licensed registered nurse (RN) shall perform a medical assessment to determine necessary supports and services which shall be addressed in the ISP.

3. The assessment shall be conducted prior to admission and at least annually thereafter. The assessment may be conducted more often as the client's needs change.

4. An HCBS comprehensive assessment performed for a client in accordance with policies and procedures established by Medicaid or by a DHH program office for reimbursement purposes can substitute for the assessment required under these provisions.

D. Service Agreement

1. An HCBS provider shall ensure that a written service agreement is completed prior to admission of a client. A copy of the agreement, signed by all parties involved, shall be maintained in the client's record and shall be made available upon request by the department, the client and the legal representative, where appropriate.

2. The service agreement shall include:

a. a delineation of the respective roles and responsibilities of the provider;

b. specification of all of the services to be rendered by the provider;

c. the provider's expectations concerning the client; and

d. specification of the financial arrangements, including any fees to be paid by the client.

3. An HCBS plan of care or agreement to provide services signed by the provider or client in accordance with policies and procedures established by Medicaid or by a DHH program office for reimbursement purposes can substitute for the agreement required under these provisions.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2120.1.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:77 (January 2012).

§5041. Individual Service Plan

A. Upon admission and prior to the initiation of care and services, an individual service plan shall be developed for each client based upon a comprehensive assessment.

B. The client shall participate in the planning process. If the client is unable to participate in all or part of the planning, the provider shall document the parts or times and reasons why the client did not participate.

C. The agency shall document that they consulted with the client or legal representative regarding who should be involved in the planning process.

D. The agency shall document who attends the planning meeting.

E. The provider shall ensure that the ISP and any subsequent revisions are explained to the client receiving services and, where appropriate, the legal representative, in language that is understandable to them.

F. The ISP shall include the following components:

1. the findings of the comprehensive assessment;

2. a statement of goals to be achieved or worked towards for the person receiving services and their family or legal representative;

3. daily activities and specialized services that will be provided directly or arranged for;

4. target dates for completion or re-evaluation of the stated goals; and

5. identification of all persons responsible for implementing or coordinating implementation of the plan.

G. The provider shall ensure that all agency staff working directly with the person receiving services are appropriately informed of and trained on the ISP.

H. A comprehensive plan of care prepared in accordance with policies and procedures established by Medicaid or by a DHH program office for reimbursement purposes may be substituted for the individual service plan.

I. Each client's ISP shall be reviewed, revised, updated and amended annually, and more often as necessary, to reflect changes in the client's needs, services and personal outcomes.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2120.1.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:77 (January 2012).

§5043. Contract Services

A. A provider may enter into contracts or other agreements with other companies or individuals to provide

services to a client. The provider is still responsible for the management of the client's care and for all services provided to the client by the contractor or its personnel.

B. When services are provided through contract, a written contract must be established. The contract shall include all of the following items:

1. designation of the services that are being arranged for by contract;

2. specification of the period of time that the contract is to be in effect;

3. a statement that the services provided to the client are in accordance with the individual service plan;

4. a statement that the services are being provided within the scope and limitations set forth in the individual service plan and may not be altered in type, scope or duration by the contractor;

5. assurance that the contractor meets the same requirements as those for the provider's staff, such as staff qualifications, functions, evaluations, orientation and in-service training;

a. the provider shall be responsible for assuring the contractor's compliance with all personnel and agency policies required for HCBS providers during the contractual period;

6. assurance that the contractor completes the clinical record in the same timely manner as required by the staff of the provider;

7. payment of fees and terms; and

8. assurance that reporting requirements are met.

C. The provider and contractor shall document review of their contract on an annual basis.

D. The provider shall coordinate services with contract personnel to assure continuity of client care.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2120.1.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:77 (January 2012).

§5045. Transportation

A. An HCBS provider shall arrange for or provide transportation necessary for implementing the client's service plan.

B. Any vehicle owned by the agency or its employees used to transport clients shall be:

1. properly licensed and inspected in accordance with state law;

2. maintained in a safe condition;

3. operated at a temperature that does not compromise the health, safety or needs of the client.

C. The provider shall have proof of liability insurance coverage for any vehicle owned by the agency or its employees that are used to transport clients. The personal liability insurance of a provider's employee shall not be substituted for the required coverage.

D. Any staff member of the provider, or other person acting on behalf of the provider, who is operating a vehicle owned by the agency or its employees for the purpose of transporting clients shall be properly licensed to operate that class of vehicle in accordance with state law.

E. The provider shall have documentation of successful completion of a safe driving course for each employee who transports clients.

1. Employees shall successfully complete a safe driving course within 90 days of hiring, every three years thereafter, and within 90 days of the provider's discovery of any moving violation.

F. Upon hire, the provider shall conduct a driving history record of each employee, and annually thereafter.

G. The provider shall not allow the number of persons in any vehicle used to transport clients to exceed the number of available seats with seatbelts in the vehicle.

H. The provider shall ascertain the nature of any need or problem of a client which might cause difficulties during transportation. This information shall be communicated to agency staff who will transport clients.

I. The following additional arrangements are required for transporting non-ambulatory clients who cannot otherwise be transferred to and from the vehicle.

1. A ramp device to permit entry and exit of a client from the vehicle shall be provided for vehicles.

a. A mechanical lift may be utilized, provided that a ramp is also available in case of emergency, unless the mechanical lift has a manual override.

2. Wheelchairs used in transit shall be securely fastened inside the vehicle utilizing approved wheelchair fasteners.

3. The arrangement of the wheelchairs shall not impede access to the exit door of the vehicle.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2120.1.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:78 (January 2012).

Subchapter E. Client Protections

§5049. Client Rights

A. Unless adjudicated by a court of competent jurisdiction, clients served by HCBS providers shall have the same rights, benefits and privileges guaranteed by the constitution and the laws of the United States and Louisiana.

B. There shall be written policies and procedures that protect the client's welfare, including the means by which the protections will be implemented and enforced.

C. Each HCBS provider's written policies and procedures, at a minimum, shall ensure the client's right to:

1. human dignity;

2. impartial access to treatment regardless of race, religion, sex, ethnicity, age or disability;

3. cultural access as evidenced by:

a. interpretive services;

b. translated materials;

c. the use of native language when possible; and

d. staff trained in cultural awareness;

4. have sign language interpretation, allow for the use of service animals and/or mechanical aids and devices that assist those persons in achieving maximum service benefits when the person has special needs;

5. privacy;

6. confidentiality;

7. access his/her records upon the client's written consent for release of information;

8. a complete explanation of the nature of services and procedures to be received, including:

a. risks;

b. benefits; and

c. available alternative services;

9. actively participate in services, including:

a. assessment/reassessment;

b. service plan development; and

c. discharge;

10. refuse specific services or participate in any activity that is against their will and for which they have not given consent;

11. obtain copies of the provider's complaint or grievance procedures;

12. file a complaint or grievance without retribution, retaliation or discharge;

13. be informed of the financial aspect of services;

14. be informed of the need for parental or guardian consent for treatment of services, if appropriate;

15. personally manage financial affairs, unless legally determined otherwise;

16. give informed written consent prior to being involved in research projects;

17. refuse to participate in any research project without compromising access to services;

18. be free from mental, emotional and physical abuse and neglect;

19. be free from chemical or physical restraints;

20. receive services that are delivered in a professional manner and are respectful of the client's wishes concerning their home environment;

21. receive services in the least intrusive manner appropriate to their needs;

22. contact any advocacy resources as needed, especially during grievance procedures; and

23. discontinue services with one provider and freely choose the services of another provider.

D. An HCBS provider shall assist in obtaining an independent advocate:

1. if the client's rights or desires may be in jeopardy;

2. if the client is in conflict with the provider; or

3. upon any request of the client.

E. The client has the right to select an independent advocate, which may be:

1. a legal assistance corporation;

2. a state advocacy and protection agency;

3. a trusted church or family member; or

4. any other competent key person not affiliated in any way with the licensed provider.

F. The client, client's family and legal guardian, if one is known, shall be informed of their rights, both verbally and in writing in a language they are able to understand.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2120.1.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:78 (January 2012).

§5051. Grievances

A. The agency shall establish and follow a written grievance procedure to be used to formally resolve complaints by clients, their family member(s) or a legal representative regarding provision of services. The written grievance procedure shall be provided to the client.

1. The notice of grievance procedure shall include the names of organizations that provide free legal assistance.

B. The client, family member or legal representative shall be entitled to initiate a grievance at any time.

C. The agency shall annually explain the grievance procedure to the client, family member(s) or a legal representative, utilizing the most appropriate strategy for ensuring an understanding of what the grievance process entails.

1. The agency shall provide the grievance procedure in writing and grievance forms shall be made available.

D. The administrator of the agency, or his/her designee, shall investigate all grievances and shall make all reasonable attempts to address the grievance.

E. The administrator of the agency, or his/her designee, shall issue a written report and/or decision within five business days of receipt of the grievance to the:

1. client;

2. client's advocate;

3. authorized representative; and

4. the person making the grievance.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2120.1.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:79 (January 2012).

Subchapter F. Provider Responsibilities

§5053. General Provisions

A. HCBS providers shall have qualified staff sufficient in number to meet the needs of each client as specified in the ISP and to respond in emergency situations.

B. Additional staff shall be employed as necessary to ensure proper care of clients and adequate provision of services.

C. Staff shall have sufficient communication and language skills to enable them to perform their duties and interact effectively with clients and other staff persons.

D. All client calls to the provider's published telephone number shall be returned within an appropriate amount of time not to exceed one business day. Each client shall be informed of the provider's published telephone number, in writing, as well as through any other method of communication most readily understood by the client according to the following schedule:

1. upon admission to the HCBS provider agency;

2. at least once per year after admission; and

3. when the provider's published telephone number changes.

E. HCBS providers shall establish policies and procedures relative to the reporting of abuse and neglect of clients, pursuant to the provisions of R.S. 15:1504-1505, R.S. 40:2009.20 and any subsequently enacted laws. Providers shall ensure that staff complies with these regulations.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2120.1.

HISTORY NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:79 (January 2012).

§5055. Core Staffing Requirements

A. Administrative Staff. The following administrative staff is required for all HCBS providers:

1. a qualified administrator at each licensed geographic location who shall meet the qualifications as established in these provisions; and

2. other administrative staff as necessary to properly safeguard the health, safety and welfare of the clients receiving services.

B. Administrator Qualifications

1. The administrator shall be a resident of the state of Louisiana and shall have a minimum of the following educational qualifications and experience:

a. a bachelor's degree; and

b. a minimum of four years of verifiable experience working in a field providing services to the elderly and/or persons with developmental disabilities.

2. Any person convicted of a felony as defined in these provisions is prohibited from serving as the administrator of an HCBS provider agency.

C. Administrator Responsibilities. The administrator shall:

1. be a full time employee of the HCBS provider and shall not be a contract employee;

2. be available in person or by telecommunication at all times for all aspects of agency operation or designate in writing an individual to assume the authority and control of the agency if the administrator is temporarily unavailable;

3. direct the operations of the agency;

4. be responsible for compliance with all regulations, laws, policies and procedures applicable to home and community-based service providers;

5. employ qualified individuals and ensure adequate staff education and evaluations;

6. ensure the accuracy of public information and materials;

7. act as liaison between staff, contract personnel and the governing body;

8. implement an ongoing, accurate and effective budgeting and accounting system;

9. ensure that all staff receive proper orientation and training on policies and procedures, client care and services and documentation, as required by law or as necessary to fulfill each staff person's responsibilities;

10. assure that services are delivered according to the client's individual service plan; and

11. not serve as administrator for more than one licensed HCBS provider.

D. Professional Services Staff

1. The provider shall employ, contract with or assure access to all necessary professional staff to meet the needs of each client as identified and addressed in the client's ISP. The professional staff may include, but not be limited to:

a. licensed practical nurses;

b. registered nurses;

c. speech therapists;

d. physical therapists;

e. occupational therapists;

f. social workers; and

g. psychologists.

2. Professional staff employed or contracted by the provider shall hold a current, valid license issued by the appropriate licensing board and shall comply with continuing education requirements of the appropriate board.

3. The provider shall maintain proof of annual verification of current license of all professional staff.

4. All professional services furnished or provided shall be provided in accordance with acceptable professional practice standards, according to the scope of practice requirements for each licensed discipline.

E. Direct Care Staff

1. The provider shall be staffed with direct care staff to properly safeguard the health, safety and welfare of clients.

2. The provider shall employ direct care staff to ensure the provision of home and community-based services as required by the ISP.

3. The HCBS provider shall ensure that each client who receives HCBS services has a written individualized back-up staffing plan and agreement for use in the event that the assigned direct care staff is unable to provide support due to unplanned circumstances, including emergencies which arise during a shift. A copy of the individualized plan and agreement shall be provided to the client and/or the client's legally responsible party, and if applicable, to the support coordinator, within five working days of the provider accepting the client.

F. Direct Care Staff Qualifications

1. All providers who receive state or federal funds, and compensate their direct service workers with such funds, shall ensure that all non-licensed direct care staff meet the minimum mandatory qualifications and requirements for direct service workers as required by R.S. 40:2179-40:2179.1 or a subsequently amended statute and any rules published pursuant to those statutes.

2. All direct care staff shall have the ability to read, write and carry out directions competently as assigned.

a. The training must address areas of weakness, as determined by the worker's performance reviews, and may address the special needs of clients.

3. All direct care staff shall be trained in recognizing and responding to the medical emergencies of clients.

G. Direct Care Staff Responsibilities. The direct care staff shall:

1. provide personal care services to the client, per the ISP;

2. provide the direct care services to the client at the time and place assigned;

3. report and communicate changes in a client's condition to a supervisor immediately upon discovery of the change;

4. report and communicate a client's request for services or change in services to a supervisor within 24 hours of the next business day of such request;

5. follow emergency medical training while attending the client;

6. subsequently report any medical or other types of emergencies to the supervisor, the provider or others, pursuant to the provider policies and procedures;

7. report any suspected abuse, neglect or exploitation of clients to a supervisor on the date of discovery, and as required by law;

8. be trained on daily documentation such as progress notes and progress reports; and

9. be responsible for daily documentation of services provided and status of clients to be reported on progress notes and/or progress reports.

H. Volunteers/Student Interns

1. A provider utilizing volunteers or student interns on a regular basis shall have a written plan for using such resources. This plan shall be given to all volunteers and interns. The plan shall indicate that all volunteers and interns shall:

a. be directly supervised by a paid staff member;

b. be oriented and trained in the philosophy, policy and procedures of the provider, confidentiality requirements and the needs of clients; and

c. have documentation of three reference checks.

2. Volunteer/student interns shall be a supplement to staff employed by the provider but shall not provide direct care services to clients.

I. Direct Care Staff Supervisor. The HCBS provider shall designate and assign a direct care staff supervisor to monitor and supervise the direct care staff.

1. The supervisor shall be selected based upon the needs of the client outlined in the ISP.

2. A provider may have more than one direct care staff supervisor.

3. Staff in supervisor positions shall have annual training in supervisory and management techniques.

J. Direct Care Supervision

1. A direct care staff supervisor shall make an in-person supervisory visit of each direct care staff within 60 days of hire and at least annually thereafter. Supervisory visits shall occur more frequently:

a. if dictated by the ISP;

b. as needed to address worker performance;

c. to address a client's change in status; or

d. to assure services are provided in accordance with the ISP.

2. The supervisory visit shall be unannounced and utilized to evaluate:

a. the direct care staff's ability to perform assigned duties;

b. whether services are being provided in accordance with the ISP; and

c. if goals are being met.

3. Documentation of supervision shall include:

a. the worker/client relationship;

b. services provided;

c. observations of the worker performing assigned duties;

d. instructions and comments given to the worker during the onsite visit; and

e. client satisfaction with service delivery.

4. An annual performance evaluation for each direct care staff person shall be documented in his/her personnel record.

5. In addition to the in-person supervisory visits conducted with direct care staff, the provider shall visit the home of each client on a quarterly basis to determine whether the individual:

a. service plan is adequate;

b. continues to need the services; and

c. service plan needs revision.

K. Direct Care Staff Training

1. The provider shall ensure that each direct care staff satisfactorily completes a minimum of 16 hours of training upon hire and before providing direct care and services to clients. Such training shall include the following topics and shall be documented, maintained and readily available in the agency's records:

a. the provider's policies and procedures;

b. emergency and safety procedures;

c. recognizing and responding to medical emergencies that require an immediate call to 911;

d. client's rights;

e. detecting and reporting suspected abuse and neglect, utilizing the department's approved training curriculum;

f. reporting critical incidents;

g. universal precautions;

h. documentation;

i. implementing service plans;

j. confidentiality;

k. detecting signs of illness or dysfunction that warrant medical or nursing intervention;

l. basic skills required to meet the health needs and problems of the client; and

m. the management of aggressive behavior, including acceptable and prohibited responses.

2. The provider shall ensure that each direct care staff satisfactorily completes a basic first aid course within 45 days of hire.

L. Competency Evaluation

1. A competency evaluation must be developed and conducted to ensure that each direct care staff, at a minimum, is able to demonstrate competencies in the training areas in §5055.K.

2. Written or oral examinations shall be provided.

3. The examination shall reflect the content and emphasis of the training curriculum components in §5055.K and shall be developed in accordance with accepted educational principles.

4. A substitute examination, including an oral component, will be developed for those direct care staff with limited literacy skills. This examination shall contain all of the content that is included in the written examination and shall also include a written reading comprehension component that will determine competency to read job-related information.

M. Continuing Education

1. Annually thereafter, the provider shall ensure that each direct care staff person satisfactorily completes a minimum of 16 hours of continuing training in order to ensure continuing competence. Orientation and normal supervision shall not be considered for meeting this requirement. This training shall address the special needs of clients and may address areas of employee weakness as determined by the direct care staff's performance reviews.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2120.1.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:79 (January 2012).

§5057. Client Records

A. Client records shall be maintained in the HCBS provider's office. Current progress notes shall be maintained at the home. The provider shall have a written record for each client which shall include:

1. other identifying data including:
   a. name;
   b. date of birth;
   c. address;
   d. telephone number;
   e. social security number;
   f. legal status; and
   g. proof of interdiction or continuing tutorship, if applicable.
2. a copy of the client's ISP or Medicaid comprehensive plan of care, as well as any modifications or updates to the service plan;
3. the client's history including, where applicable:
   a. family data;
   b. next of kin;
   c. educational background;
   d. employment record;
   e. prior medical history; and
   f. prior service history;
4. the service agreement or comprehensive plan of care;
5. written authorization signed by the client or, where appropriate, the legally responsible person for emergency care;
6. written authorization signed by the client or, where appropriate, the legally responsible person for managing the client's money, if applicable;
7. a full and complete separate accounting of each client's personal funds which includes a written record of all of the financial transactions involving the personal funds of the client deposited with the provider;
   a. the client (or his legal representative) shall be afforded reasonable access to such record;
   b. the financial records shall be available through quarterly statements;
   c. the provider shall safeguard and account for any such funds;
8. required assessment(s) and additional assessments that the provider may have received or is privy to;
9. the names, addresses and telephone numbers of the client's physician(s) and dentist;
10. written progress notes or equivalent documentation and reports of the services delivered for each client for each visit. The written progress notes shall include, at a minimum:
    a. the date and time of the visit and services;
    b. the services delivered;
    c. who delivered or performed the services;
    d. observed changes in the physical and mental condition(s) of the client, if applicable; and
    e. doctor appointments scheduled or attended that day;
11. health and medical records of the client, including:
    a. a medical history, including allergies;
    b. a description of any serious or life threatening medical condition(s);
    c. a description of any medical treatment or medication necessary for the treatment of any medical condition; and
    d. physician delegation form for the administration of medication or treatment, if applicable; and
12. a copy of any advance directive that has been provided to the HCBS provider, or any physician orders relating to end of life care and services.

B. HCBS providers shall maintain client records for a period of five years.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2120.1.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:82 (January 2012).

§5059. Client Funds and Assets

A. The HCBS provider shall not require that they be the manager of the client's funds and shall develop and implement written policies and procedures to protect client funds.

B. In the case of a representative payee, all social security rules and regulations shall be adhered to.

C. If the provider manages a client's personal funds, the provider must furnish a written statement which includes the client's rights regarding personal funds, a list of the services offered and charges, if any, to the client and/or his/her legal or responsible representative.

D. If a client chooses to entrust funds with the provider, the provider shall obtain written authorization from the client and/or his/her legal or responsible representative for the safekeeping and management of the funds.

E. The provider shall:

1. provide each client with an account statement on a quarterly basis with a receipt listing the amount of money the provider is holding in trust for the client;
2. maintain a current balance sheet containing all financial transactions;
3. provide a list or account statement regarding personal funds upon request of the client;
4. maintain a copy of each quarterly account statement in the client's record;
5. keep funds received from the client for management in a separate account and maintain receipts from all purchases with each receipt being signed by the client and the staff assisting the client with the purchase, or by the staff assisting the client with the purchase and an independent staff when the client is not capable of verifying the purchase; and
6. not commingle the clients' funds with the provider's operating account.

F. A client with a personal fund account managed by the HCBS provider may sign an account agreement acknowledging that any funds deposited into the personal account, by the client or on his/her behalf, are jointly owned by the client and his legal representative or next of kin. These funds do not include Social Security funds that are restricted by Social Security Administration (SSA) guidelines. The account agreement shall state that:

1. the funds in the account shall be jointly owned with the right of survivorship;

2. the funds in the account shall be used by the client or on behalf of the client;

3. the client or the joint owner may deposit funds into the account;

4. the client or joint owner may endorse any check, draft or other instrument to the order of any joint owner, for deposit into the account; and

5. the joint owner of a client's account shall not be an employee of the provider.

G. If the provider is managing funds for a client and he/she is discharged, any remaining funds shall be refunded to the client or his/her legal or responsible representative within five business days of notification of discharge.

H. Distribution of Funds upon the Death of a Client

1. Upon the death of a client, the provider shall act accordingly upon any burial or insurance policies of the client.

2. Unless otherwise provided by state law, upon the death of a client, the provider shall provide the executor or administrator of the client's estate or the client's responsible representative with a complete account statement of the client's funds and personal property being held by the provider.

3. If a valid account agreement has been executed by the client, the provider shall transfer the funds in the client's personal fund account to the joint owner within 30 days of the client's death. This provision only applies to personal fund accounts not in excess of $2,000.

4. If a valid account agreement has not been executed, the provider shall comply with the federal and state laws and regulations regarding the disbursement of funds in the account and the properties of the deceased. The provider shall comply with R.S. 9:151–181, the Louisiana Uniform Unclaimed Property Act, and the procedures of the Louisiana Department of the Treasury regarding the handling of a deceased client's funds that remain unclaimed.

I. A termination date of the account and the reason for termination shall be recorded on the client's participation file. A notation shall read, "to close account." The endorsed cancelled check with check number noted on the ledger sheet shall serve as sufficient receipt and documentation.

J. Burial or Insurance Policies. Upon discharge of a client, the provider shall release any burial policies or insurance policies to the client or his/her legal or responsible representative.

K. The provisions of this section shall have no effect on federal or state tax obligations or liabilities of the deceased client's estate. If there are other laws or regulations which conflict with these provisions, those laws or regulations will govern over and supersede the conflicting provisions.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2120.1.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:82 (January 2012).

§5061. Quality Enhancement Plan

A. An HCBS provider shall have a quality enhancement (QE) plan which puts systems in place to effectively identify issues for which quality monitoring, remediation and improvement activities are necessary. The QE plan includes plans of action to correct identified issues including monitoring the effect of implemented changes and making needed revisions to the action plan.

B. The QE program outcomes shall be reported to the administrator for action, as necessary, for any identified systemic problems.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2120.1.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:83 (January 2012).

§5063. Emergency Preparedness

A. A disaster or emergency may be a local, community-wide, regional or statewide event. Disasters or emergencies may include, but are not limited to:

1. tornados;
2. fires;
3. floods;
4. hurricanes;
5. power outages;
6. chemical spills;
7. biohazards;
8. train wrecks; or
9. declared health crisis.

B. Providers shall ensure that each client has an individual plan for dealing with emergencies and disasters and shall assist clients in identifying the specific resources available through family, friends, the neighborhood and the community.

C. Continuity of Operations. The provider shall have an emergency preparedness plan to maintain continuity of the agency's operations in preparation for, during and after an emergency or disaster. The plan shall be designed to manage the consequences of all hazards, declared disasters or other emergencies that disrupt the provider's ability to render care and treatment, or threatens the lives or safety of the clients.

D. The provider shall follow and execute its emergency preparedness plan in the event of the occurrence of a declared disaster or other emergency. The plan shall include, at a minimum:

1. provisions for the delivery of essential services to each client as identified in the individualized emergency plan for each client, whether the client is in a shelter or other location;

2. provisions for the management of staff, including provisions for adequate, qualified staff as well as for distribution and assignment of responsibilities and functions;

3. provisions for back-up staff;

4. the method that the provider will utilize in notifying the client's family or caregiver if the client is evacuated to another location either by the provider or with the assistance or knowledge of the provider. This notification shall include:

a. the date and approximate time that the facility or client is evacuating;

b. the place or location to which the client(s) is evacuating which includes the name, address and telephone number; and

c. a telephone number that the family or responsible representative may call for information regarding the provider's evacuation;

5. provisions for ensuring that supplies, medications, clothing and a copy of the service plan are sent with the client, if the client is evacuated; and

6. the procedure or methods that will be used to ensure that identification accompanies the individual. The identification shall include the following information:

a. current and active diagnosis;

b. medication, including dosage and times administered;

c. allergies;

d. special dietary needs or restrictions; and

e. next of kin, including contact information.

E. If the state, parish or local Office of Homeland Security and Emergency Preparedness (OHSEP) orders a mandatory evacuation of the parish or the area in which the agency is serving, the agency shall ensure that all clients are evacuated according to the client's individual plan and the agency's emergency preparedness plan.

1. The provider shall not abandon a client during a disaster or emergency. The provider shall not evacuate a client to a shelter without ensuring staff and supplies remain with the client at the shelter, in accordance with the client's service plan.

F. Emergency Plan Review and Summary. The provider shall review and update its emergency preparedness plan, as well as each client's emergency plan at least annually.

G. The provider shall cooperate with the department and with the local or parish OHSEP in the event of an emergency or disaster and shall provide information as requested.

H. The provider shall monitor weather warnings and watches as well as evacuation order from local and state emergency preparedness officials.

I. All agency employees shall be trained in emergency or disaster preparedness. Training shall include orientation, ongoing training and participation in planned drills for all personnel.

J. Upon request by the department, the HCBSP shall submit a copy of its emergency preparedness plan and a written summary attesting how the plan was followed and executed. The summary shall contain, at a minimum:

1. pertinent plan provisions and how the plan was followed and executed;

2. plan provisions that were not followed;

3. reasons and mitigating circumstances for failure to follow and execute certain plan provisions;

4. contingency arrangements made for those plan provisions not followed; and

5. a list of all injuries and deaths of clients that occurred during execution of the plan, evacuation or temporary relocation including the date, time, causes and circumstances of the injuries and deaths.

K. Inactivation of License due to a Declared Disaster or Emergency.

1. An HCBS provider licensed in a parish which is the subject of an executive order or proclamation of emergency or disaster, as issued in accordance with R.S. 29:724 or R.S. 29:766 may seek to inactivate its license for a period not to exceed one year, provided that the following conditions are met:

a. the licensed provider shall submit written notification to the Health Standards Section within 60 days of the date of the executive order or proclamation of emergency or disaster that:

i. the HCBS provider has experienced an interruption in the provisions of services as a result of events that are the subject of such executive order or proclamation of emergency or disaster issued in accordance with R.S. 29:724 or R.S. 29:766;

ii. the licensed HCBS provider intends to resume operation as an HCBS provider in the same service area;

iii. includes an attestation that the emergency or disaster is the sole casual factor in the interruption of the provision of services;

iv. includes an attestation that all clients have been properly discharged or transferred to another provider; and

v. provides a list of each client and where that client is discharged or transferred to;

b. the licensed HCBS provider resumes operating as a HCBS provider in the same service area within one year of the issuance of an executive order or proclamation of emergency or disaster in accordance with R.S. 29:724 or R.S. 29:766;

c. the licensed HCBS provider continues to pay all fees and cost due and owed to the department including, but not limited to, annual licensing fees and outstanding civil monetary penalties; and

d. the licensed HCBS provider continues to submit required documentation and information to the department.

2. Upon receiving a completed written request to inactivate a HCBS provider license, the department shall issue a notice of inactivation of license to the HCBS provider.

3. Upon completion of repairs, renovations, rebuilding or replacement, an HCBS provider which has received a notice of inactivation of its license from the department shall be allowed to reinstate its license upon the following conditions being met.

a. The HCBS provider shall submit a written license reinstatement request to the licensing agency of the department 60 days prior to the anticipated date of reopening.

b. The license reinstatement request shall inform the department of the anticipated date of opening, and shall request scheduling of a licensing survey.

c. The license reinstatement request shall include a completed licensing application with appropriate licensing fees.

d. The provider resumes operating as an HCBS provider in the same service area within one year.

4. Upon receiving a completed written request to reinstate an HCBS provider license, the department shall conduct a licensing survey. If the HCBS provider meets the requirements for licensure and the requirements under this Section, the department shall issue a notice of reinstatement of the HCBS provider license.

a. The licensed capacity of the reinstated license shall not exceed the licensed capacity of the HCBS provider at the time of the request to inactivate the license.

5. No change of ownership in the HCBS provider shall occur until such HCBS provider has completed repairs, renovations, rebuilding or replacement construction, and has resumed operations as an HCBS provider.

6. The provisions of this Section shall not apply to an HCBS provider which has voluntarily surrendered its license and ceased operation.

7. Failure to comply with any of the provisions of this Section shall be deemed a voluntary surrender of the HCBS provider license and any applicable facility need review approval for licensure.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2120.1.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:83 (January 2012).

Subchapter G. Adult Day Care Module

§5071. General Provisions

A. Providers applying for the Adult Day Care module under the HCBS license shall meet the core licensing requirements as well as the module specific requirements of this Section.

B. Adult Day Care is designed to meet the individual needs of functionally impaired adults. This is a structured and comprehensive group program which provides a variety of health, social, and related support services in a protective setting for a portion of the 24-hour day.

C. An ADC program shall provide services for 10 or more functionally impaired adults who are not related to the owner or operator of the HCBS provider.

1. For the purposes of this Section, "*functionally impaired adult*" shall be defined as individuals 17 years of age or older who are physically, mentally or socially impaired to a degree that requires supervision.

D. The following two programs shall be provided under the ADC Module:

1. Day Habilitation Services

a. Day habilitation services include assistance with acquisition, retention or improvement in self-help, socialization, and adaptive skills that take place in a non-residential setting separate from the recipient's private residence or other residential living arrangement. Day habilitation services provide activities and environments designed to foster the acquisition of skills, appropriate behavior, greater independence and personal choice.

b. Services are furnished to a client who is 17 years of age or older and has a developmental disability, or who is a functionally impaired adult, on a regularly scheduled basis during normal daytime working hours for one or more days per week, or as specified in the recipient's service plan.

c. Day habilitation services focus on enabling the recipient to attain or maintain his or her maximum functional level, and shall be coordinated with any physical, occupational, or speech therapies in the service plan. These services may also serve to reinforce skills or lessons taught in other settings.

2. Prevocational/Employment-Related Services

a. Prevocational/employment-related services prepare a recipient for paid or unpaid employment. Services include teaching such concepts as compliance, attendance, task completion, problem solving and safety. Services are not job-task oriented, but are aimed at a generalized result. These services are reflected in the recipient's service plan and are directed to habilitative (e.g. attention span, motor skills) rather than explicit employment objectives.

b. Prevocational services are provided to clients who are not expected to join the general work force or participate in a transitional sheltered workshop within one year of service initiation.

c. This service is not available to clients eligible to receive services under a program funded under the Rehabilitation Act of 1973 or the IDEA.

E. When applying for the ADC module under the HCBS provider license, the provider shall indicate whether it is providing day habilitation, prevocational/employment-related services or both.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2120.1.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:85 (January 2012).

§5073. Operational Requirements for ADC Facilities

A. The client/staff ratio in an ADC facility shall be one staff person per eight clients, unless additional staff coverage is needed to meet the needs of the client, as specified in the service plan.

B. Staff Training

1. ADC Staff in supervisory positions shall have annual training in supervisory and management techniques.

2. Each ADC facility shall have a training supervisor who shall receive at least 15 hours of annual vocational and/or community-based employment training.

3. Once the training supervisor receives all of the required training, he/she shall be responsible for ensuring that direct care staff receives training on vocational and/or community-based employment training.

C. Food and Nutrition

1. If meals are prepared by the facility or contracted from an outside source, the following conditions shall be met:

a. menus shall be written in advance and shall provide for a variety of nutritional foods;

b. records of menus, as served, shall be filed and maintained for at least 30 days;

c. modified diets shall be prescribed by a physician;

d. only food and drink of safe quality shall be purchased;

e. storage, preparation, and serving techniques shall be provided to ensure nutrients are retained and spoilage is prevented;

f. food preparation areas and utensils shall be kept clean and sanitary;

g. there shall be an adequate area for eating; and

h. the facility shall designate one staff member who shall be responsible for meal preparation/serving if meals are prepared in the facility.

2. When meals are not prepared by the facility, the following conditions shall be met:

a. provisions shall be made for obtaining food for clients who do not bring their lunch; and

b. there shall be an adequate area for eating.

3. Drinking water shall be readily available. If a water fountain is not available, single-use disposable cups shall be used.

4. Dining areas shall be adequately equipped with tables, chairs, eating utensils and dishes designed to meet the functional needs of clients.

5. Adequate refrigeration of food shall be maintained.

D. General Safety Practices

1. A facility shall not maintain any firearms or chemical weapons at any time.

2. A facility shall ensure that all poisonous, toxic and flammable materials are safely secured and stored in appropriate containers and labeled as to the contents. Such materials shall be maintained only as necessary and shall be used in such a manner as to ensure the safety of clients, staff and visitors.

3. Adequate supervision/training shall be provided where potentially harmful materials such as cleaning solvents and/or detergents are used.

4. A facility shall ensure that a first aid kit is available in the facility and in all vehicles used to transport clients.

5. Medication shall be locked in a secure storage area or cabinet.

6. Fire drills shall be performed at least once a month.

E. Physical Environment

1. The ADC building shall be constructed, equipped and maintained to ensure the safety of all individuals. The building shall be maintained in good repair and kept free from hazards such as those created by any damage or defective parts of the building.

2. The provider shall maintain all areas of the facility that are accessible to individuals, and ensure that all structures on the ground of the facility are in good repair and kept free from any reasonable foreseeable hazards to health or safety.

3. The facility shall be accessible to and functional for those cared for, the staff and the public. All necessary accommodations shall be made to meet the needs of clients. Training or supports shall be provided to help clients effectively negotiate their environments.

4. There shall be a minimum of 35 square feet of space per client. Kitchens, bathrooms and halls used as passageways, and other spaces not directly associated with program activities, shall not be considered as floor space available to clients.

5. There shall be storage space, as needed by the program, for training and vocational materials, office supplies, and client's personal belongings.

6. Rooms used for recipient activities shall be well ventilated and lighted.

7. Chairs and tables shall be adequate in number to serve the clients.

8. Bathrooms and lavatories shall be accessible, operable and equipped with toilet paper, soap and paper towels or hand drying machines.

a. The ratio of bathrooms to number of clients shall meet the requirements in Table 407 of the State Plumbing Code.

b. Individuals shall be provided privacy when using bathroom facilities.

c. Every bathroom door shall be designed to permit opening of the locked door from the outside, in an emergency, and the opening device shall be readily accessible to the staff.

9. Stairways shall be kept free of obstruction and fire exit doors shall be maintained in working order. All stairways shall be equipped with handrails.

10. There shall be a telephone available and accessible to all clients.

11. The ADC shall be equipped with a functional air conditioning and heating unit(s) which maintains an ambient temperature between 65 and 80 degrees Fahrenheit throughout the ADC or in accordance with industry standards, if applicable.

12. The building in which the ADC is located shall meet the standards of the Americans with Disabilities Act.

F. Employment of Clients

1. The provider shall meet all of the state and federal wage and hour regulations regarding employment of clients who are admitted to the agency.

a. The provider must maintain full financial records of clients' earnings if the facility pays the client.

b. The provider shall have written assurance that the conditions and compensation of work are in compliance with applicable state and federal employment regulations.

c. The provider must have a U.S. Department of Labor Sub-Minimum Wage Certificate if the provider pays sub-minimum wage.

2. Clients shall not be required to perform any kind of work involving the operation or maintenance of the facility without compensation in accordance with the U.S. Department of Labor sub-minimum standard.

3. Clients shall be directly supervised when operating any type of power driven equipment such as lawn mowers or electrical saws, unless:

a. the ID team has determined that direct supervision is not necessary;

b. equipment has safety guards or devices; and

c. adequate training is given to the recipient and the training is documented.

4. Clients shall be provided with the necessary safety apparel and safety devices to perform the job.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2120.1.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:85 (January 2012).

Subchapter H. Family Support Module

§5075. General Provisions

A. Providers applying for the Family Support module under the HCBS license shall meet the core licensing requirements as well as the module specific requirements of this Section.

B. The purpose of family support services is to:

1. keep the family of a person with a disability together by promoting unity, independence of the family in problem solving and maintenance of the family as the primary responsible caretaker;

2. determine if barriers to home placement for persons with a disability can be eliminated or relocated through financial assistance for purchases, special equipment and supplies;

3. allow a person with a disability to remain in or return to a family setting as an alternative to placement in a more restrictive setting; and

4. link families of a person with a disability to existing support services and to supplement those services where necessary (i.e. transportation to reach services when not otherwise provided).

C. Services covered by the family support module may include:

1. special equipment;
2. limited adaptive housing;
3. medical expenses and medications;
4. nutritional consultation and regime;
5. related transportation;
6. special clothing;

7. special therapies;
8. respite care;
9. dental care; and
10. family training and therapy.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2120.1.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:86 (January 2012).

§5077. Operational Requirements for Family Support Providers

A. Providers shall ensure that each family receiving services is assigned a service coordinator.

B. The service coordinator shall perform the following tasks:

1. prepare a family study, based on a home visit interview with the client, in order to ascertain what appropriate family support services may be provided;
2. visit each client at least quarterly;
3. maintain documentation of all significant contacts; and
4. review and evaluate, at least every six months, the care, support and treatment each client is receiving.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2120.1.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:87 (January 2012).

Subchapter I. Personal Care Attendant Module

§5079. General Provisions

A. Providers applying for the Personal Care Attendant module under the HCBS license shall meet the core licensing requirement as well as the module specific requirements of this Section.

B. Personal care attendant services may include:

1. assistance and prompting with:
   a. personal hygiene;
   b. dressing;
   c. bathing;
   d. grooming;
   e. eating;
   f. toileting;
   g. ambulation or transfers;
   h. behavioral support;
   i. other personal care needs; and
   j. any medical task which can be delegated;
2. assistance and/or training in the performance of tasks related to:
   a. maintaining a safe and clean home environment such as housekeeping, bed making, dusting, vacuuming and laundry;
   b. cooking;
   c. shopping;
   d. budget management;
   e. bill paying; and
   f. evacuating the home in emergency situations;
3. personal support and assistance in participating in community, health and leisure activities which may include transporting and/or accompanying the participant to these activities;
4. support and assistance in developing relationships with neighbors and others in the community and in strengthening existing informal, social networks and natural supports; and
5. enabling and promoting individualized community supports targeted toward inclusion into meaningful, integrated experiences (e.g. volunteer work and community awareness) activities.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2120.1.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:87 (January 2012).

§5081. Operational Requirements for PCA Providers

A. PCA providers shall schedule personal care attendant staff in the manner and location as required by each client's ISP.

B. PCA providers shall have a plan that identifies at least one trained and qualified back-up worker for each client served.

1. It is the responsibility of the provider to ensure that a trained and qualified back-up worker is available as needed to meet the requirements of the ISP.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2120.1.

HISTORY NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:87 (January 2012).

Subchapter J. Respite Care

§5083. General Provisions

A. Providers applying for the Respite Care module under the HCBS license shall meet the core licensing requirement as well as the applicable module specific requirements of this Section.

B. The goal of respite care is to provide temporary, intermittent relief to informal caregivers in order to help prevent unnecessary or premature institutionalization while improving the overall quality of life for both the informal caregiver and the client.

C. Respite care may be provided as an in-home or center-based service. The services may be provided in the client's home or in a licensed respite center.

D. Providers of in-home respite care services must comply with:

1. all HCBS providers core licensing requirements;
2. PCA module specific requirements; and
3. the respite care services module in-home requirements.

E. Providers of center-based respite care services must comply with:

1. all HCBS providers core licensing requirements;
2. respite care services module in-home requirements; and
3. respite care services module center-based requirements.

F. When applying for the respite care service module under the HCBS provider license, the provider shall indicate whether it is providing in-home respite care, center-based respite care or both.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2120.1.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:87 (January 2012).

§5085. Operational Requirements for In-Home Respite Care

A. All in-home respite care service providers shall:

1. make available to clients, the public and HSS the day and hours that respite is to be provided;

2. make available to clients, the public and HSS a detailed description of populations served as well as services and programming; and

B. In-home respite care service providers shall have adequate administrative, support, professional and direct care staff to meet the needs of clients at all times.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2120.1.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:88 (January 2012).

§5087. Operational Requirements for Center-Based Respite Care

A. All center-based respite care service providers shall meet the following daily aspects of care.

1. The daily schedule shall be developed in relation to the needs of the clients.

2. Clients shall be assisted in ADL's as needed.

a. The provider shall ensure that the family supplies the client with his/her own clothing.

3. The provider shall make available to each client an adequate number of supervised recreational activities.

B. All center-based respite care service providers shall meet the following health aspects of care.

1. Responsibility for the health supervision of the client shall be placed with the client's personal physician.

a. The provider shall have written agreements for obtaining diagnosis and treatment of medical and dental problems for clients who do not have a personal physician. This agreement can be with a local hospital, clinic or physician.

2. Arrangements for medical isolation shall be available. The provider shall inform the family to remove the client when necessary.

3. Medication shall be prescribed only by a licensed physician.

C. Food and Nutrition

1. Planning, preparation and serving of foods shall be in accordance with the nutritional, social, emotional and medical needs of the clients. The diet shall include a variety of food, and be attractively served. Clients shall be encouraged, but not forced, to eat all of the food served.

2. Food provided shall be of adequate quality and in sufficient quantity to provide the nutrients for proper growth and development.

3. Clients shall be provided a minimum of three meals daily, plus snacks.

4. All milk and milk products used for drinking shall be Grade A and pasteurized.

5. There shall be no more than 14 hours between the last meal or snack on one day and the first meal of the following day.

D. The provider shall request from the family that all clients over five years of age have money for personal use. Money received by a client shall be his own personal property and shall be accounted for separately from the provider's funds.

E. Privacy

1. The HCBS provider staff shall function in a manner that allows appropriate privacy for each client.

2. The space and furnishings shall be designed and planned to enable the staff to respect the clients' right to privacy and at the same time provide adequate supervision according to the ages and developmental needs of the client.

3. The provider shall not use reports or pictures, nor release (or cause to be released) research data, from which clients can be identified without written consent from the client, parents or legal guardians.

F. Contact with Family, Friends and Representatives

1. Clients in care shall be allowed to send and receive uncensored mail and conduct private telephone conversations with family members.

2. If it has been determined that the best interests of the client necessitate restrictions on communications or visits, these restrictions shall be documented in the service plan.

3. If limits on communication or visits are indicated for practical reasons, such as expense of travel or telephone calls, such limitations shall be determined with the participation of the client and family.

G. Furnishings and Equipment

1. Furnishings and equipment shall be adequate, sufficient and substantial for the needs of the age groups in care.

2. All bedrooms shall be on or above street grade level and be outside rooms. Bedrooms shall accommodate no more than four residents. Bedrooms must provide at least 60 square feet per person in multiple sleeping rooms and not less than 80 square feet in single rooms.

3. Each resident shall be provided a separate bed of proper size and height, a clean, comfortable mattress and bedding appropriate for weather and climate.

4. There shall be separate sleeping rooms for adults and for adolescents. When possible, there should be individual sleeping rooms for clients whose behavior would be upsetting to others.

5. Appropriate furniture shall be provided, such as a chest of drawers, a table or desk, an individual closet with clothes racks and shelves accessible to the residents.

6. Individual storage space reserved for the client's exclusive use shall be provided for personal possessions such as clothing and other items so that they are easily accessible to the resident during his/her stay.

H. Bath and Toilet Facilities

1. There shall be a separate toilet/bathing area for males and females beyond pre-school age. The provider shall have one toilet/bathing area for each eight clients admitted, but in no case shall have less than two toilet/bathing areas.

2. Toilets should be convenient to sleeping rooms and play rooms.

3. Toilets, bathtubs and showers shall provide for individual privacy unless specifically contraindicated for the individual, as stated in the service plan.

4. Bath/toilet area shall be accessible, operable and equipped with toilet paper, soap and paper towels or hand drying machines.

5. Every bath/toilet shall be wheelchair accessible.

6. Individuals shall be provided privacy when using a bath/toilet area.

7. Every bath/toilet area door shall be designed to permit opening of the locked door from the outside, in an emergency. The opening device shall be readily accessible to the staff.

I. There shall be a designated space for dining. Dining room tables and chairs shall be adjusted in height to suit the ages of the clients.

J. Heat and Ventilation

1. The temperature shall be maintained within a reasonable comfort range (65 to 80 degrees Fahrenheit).

2. Each habitable room shall have access to direct outside ventilation by means of windows, louvers, air conditioner, or mechanical ventilation horizontally and vertically.

K. Health and Safety

1. The facility shall comply with all applicable building codes, fire and safety laws, ordinances and regulations.

2. Secure railings shall be provided for flights of more than four steps and for all galleries more than four feet from the ground.

3. Where clients under age two are in care, gates shall be provided at the head and foot of each flight of stairs accessible to these clients.

4. Before swimming pools are made available for client use, written documentation must be received by DHH confirming that the pool meets the requirements of the Virginia Graeme Baker Pool and Spa Safety Act of 2007 or, in lieu of, written documentation confirming that the pool meets the requirements of ANSI/APSP-7 (2006 Edition) which is entitled the "American National Standard for Suction Entrapment Avoidance in Swimming Pools, Wading pools, Spas, Hot Tubs and Catch Basins."

a. An outdoor swimming pool shall be enclosed by a six foot high fence. All entrances and exits to pools shall be closed and locked when not in use. Machinery rooms shall be locked to prevent clients from entering.

b. An individual, 18 years of age or older, shall be on duty when clients are swimming in ponds, lakes or pools where a lifeguard is not on duty. The individual is to be certified in water safety by the American Red Cross.

c. There shall be written plans and procedures for water safety.

5. Storage closets or chests containing medicine or poisons shall be securely locked.

6. Garden tools, knives and other dangerous instruments shall be inaccessible to clients without supervision.

7. Electrical devices shall have appropriate safety controls.

L. Maintenance

1. Buildings and grounds shall be kept clean and in good repair.

2. Outdoor areas shall be well drained.

3. Equipment and furniture shall be safely and sturdily constructed and free of hazards to clients and staff.

4. The arrangement of furniture in living areas shall not block exit ways.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2120.1.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:88 (January 2012).

Subchapter K. Substitute Family Care Module

§5089. General Provisions

A. Providers applying for the Substitute Family Care module under the HCBS license shall meet the core licensing requirements as well as the module specific requirements of this Section. In addition to complying with the appropriate licensing regulations, SFC providers shall also establish:

1. an advisory committee comprised of persons with developmental disabilities and their families to provide guidance on the aspirations of persons with developmental disabilities who live in home and community settings;

2. a medical decision-making committee for each SFC client who is unable to give informed consent for surgical or medical treatment which shall fulfill the requirements for executing medical decision-making for those clients as required by R.S. 40.1299.53 or its successor statute.

B. Substitute family care services provide 24-hour personal care, supportive services, and supervision to adults who meet the criteria for having a developmental disability.

C. The SFC Program is designed to:

1. support individuals with developmental disabilities in a home environment in the community through an array of naturally occurring and arranged community resources similar to those enjoyed by most individuals living in the community in all stages of life;

2. expand residential options for persons with developmental disabilities;

a. this residential option also takes into account compatibility of the substitute family and the participant, including individual interests, age, health, needs for privacy, supervision and support needs;

3. provide meaningful opportunities for people to participate in activities of their choosing whereby creating a quality of life not available in other settings.

4. serve persons who require intensive services for medical, developmental or psychological challenges.

a. The SFC provider is required to provide the technical assistance, professional resources and more intensive follow-up to assure the health, safety and welfare of the client(s).

D. Substitute family care services are delivered by a principal caregiver, in the caregiver's home, under the oversight and management of a licensed SFC provider.

1. The SFC caregiver is responsible for providing the client with a supportive family atmosphere in which the availability, quality and continuity of services are appropriate to the age, capabilities, health conditions and special needs of the individual.

2. The licensed SFC provider shall not be allowed to serve as the SFC caregiver.

E. Potential clients of the SFC program shall meet the following criteria:

1. have a developmental disability as defined in R.S. 28:451.1-455.2 of the Louisiana Developmental Disability Law or its successor statute;

2. be at least 18 years of age; and

3. have an assessment and service plan pursuant to the requirements of the HCBS provider licensing rule.

a. The assessment and service plan shall assure that the individual's health, safety and welfare needs can be met in the SFC setting.

F. SFC Caregiver Qualifications

1. An SFC caregiver shall be certified by the SFC provider before any clients are served. In order to be certified, the SFC caregiver applicant shall:

a. undergo a professional home study;

b. participate in all required orientations, trainings, monitoring and corrective actions required by the SFC provider; and

c. meet all of the caregiver specific requirements of this Section.

2. The personal qualifications required for certification include:

a. Residency. The caregiver shall reside in the state of Louisiana and shall provide SFC services in the caregiver's home. The caregiver's home shall be located in the state of Louisiana and in the region in which the SFC provider is licensed.

b. Criminal Record and Background Clearance. Members of the SFC caregiver's household shall not have any felony convictions. Other persons approved to provide care or supervision of the SFC client for the SFC caregiver shall not have any felony convictions.

i. Prior to certification, the SFC caregiver, all members of the SFC caregiver applicant's household and persons approved to provide care or supervision of the SFC client on a regular or intermittent basis, shall undergo a criminal record and background check.

ii. Annually thereafter, the SFC caregiver, all members of the SFC caregiver applicant's household and persons approved to provide care or supervision of the SFC client on a regular or intermittent basis, shall have background checks.

c. Age. The SFC principal caregiver shall be at least 21 years of age. Maximum age of the SFC principal caregiver shall be relevant only as it affects his/her ability to provide for the SFC client as determined by the SFC provider through the home assessment. The record must contain proof of age.

3. The SFC caregiver may be either single or married. Evidence of marital status must be filed in the SFC provider's records and may include a copy of legal documents adequate to verify marital status.

4. The SFC caregiver is not prohibited from employment outside the home or from conducting a business in the home provided that:

a. the SFC home shall not be licensed as another healthcare provider;

b. such employment or business activities do not interfere with the care of the client;

c. such employment or business activities do not interfere with the responsibilities of the SFC caregiver to the client;

d. a pre-approved, written plan for supervision of the participant which identifies adequate supervision for the participant is in place; and

e. the plan for supervision is signed by both the SFC caregiver and the administrator or designee of the SFC provider.

G. The SFC caregiver shall not be certified as a foster care parent(s) for the Department of Social Services (DSS) while serving as a caregiver for a licensed SFC provider.

1. The SFC provider, administrator or designee shall request confirmation from DSS that the SFC caregiver applicant is not presently participating as a foster care parent and document this communication in the SFC provider's case record.

H. In addition to the discharge criteria in the core requirements, the client shall be discharged from the SFC program upon the client meeting any of the following criteria:

1. incarceration or placement under the jurisdiction of penal authorities or courts for more than 30 days;

2. lives in or changes his/her residence to another region in Louisiana or another state;

3. admission to an acute care hospital, rehabilitation hospital, intermediate care facility for persons with developmental disabilities (ICF/DD) or nursing facility with the intent to stay longer than 90 consecutive days;

4. the client and/or his legally responsible party(s) fails to cooperate in the development or continuation of the service planning process or service delivery;

5. a determination is made that the client's health and safety cannot be assured in the SFC setting; or

6. failure to participate in SFC services for 30 consecutive days for any reason other than admission to an acute care hospital, rehabilitation hospital, ICF/DD facility or nursing facility.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2120.1.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:89 (January 2012).

§5090. Operational Requirements for Substitute Family Care Providers

A. Training

1. Prior to the introduction of an SFC client into a SFC home, the SFC provider shall ensure that the caregiver receives a minimum of six hours of training designed to assure the health and safety of the client, including any areas relevant to the SFC client's support needs.

a. The provider shall also conduct a formal review of the SFC client's support needs, particularly regarding medical and behavioral concerns as well as any other pertinent areas.

2. Within the first 90 days following the client's move into the home, the SFC provider shall provide and document training to the SFC caregiver(s) on:

a. the client's support plan and the provider's responsibilities to assure successful implementation of the plan;

b. emergency plans and evacuation procedures;

c. client rights and responsibilities; and

d. any other training deemed necessary to support the person's individual needs.

3. Annually, the SFC provider shall provide the following training to the SFC caregiver:

a. six hours of approved training related to the client's needs and interests including the client's specific priorities and preferences; and

b. six hours of approved training on issues of health and safety such as the identification and reporting of allegations of abuse, neglect or exploitation.

4. On an as needed basis the SFC provider shall provide the SFC caregiver with additional training as may be deemed necessary by the provider.

B. Supervision and Monitoring. The SFC provider shall provide ongoing supervision of the SFC caregiver to ensure quality of services and compliance with licensing standards. Ongoing supervision and monitoring shall consist of the following.

1. The SFC provider shall conduct in-person monthly reviews of each SFC caregiver and/or household in order to:

a. monitor the health and safety status of the client through visits;

i. more frequent visits shall be made when concerns are identified;

b. monitor the implementation of the client's service plan to ensure that it is effective in promoting accomplishment of the client's goals;

c. assure that all services included in the service plan are readily available and utilized as planned;

d. assure that the objectives of the medical, behavioral or other plans are being accomplished as demonstrated by the client's progress; and

e. resolve discrepancies or deficiencies in service provision.

2. The SFC provider shall conduct annual reviews of each SFC caregiver and/or household in order to assure the annual certification relating to health, safety and welfare issues and the client's adjustment to the SFC setting. The annual review shall include:

a. written summaries of the SFC caregiver's performance of responsibilities and care for the client(s) placed in the home;

b. written evaluation of the strengths and needs of the SFC home and the client's relationship with the SFC caregiver, including the goals and future performance;

c. review of all of the licensing standards to ensure compliance with established standards;

d. review of any concerns or the need for corrective action, if indicated; and

e. complete annual inventory of the client's possessions.

C. The SFC provider shall assure the following minimum services are provided by the SFC caregiver:

1. 24-hour care and supervision, including provisions for:

a. a flexible, meaningful daily routine;

b. household tasks;

c. food and nutrition;

d. clothing;

e. care of personal belongings;

f. hygiene; and

g. routine medical and dental care;

2. room and board;

3. routine and reasonable transportation;

4. assurance of minimum health, safety and welfare needs;

5. participation in school, work or recreational/leisure activities, as appropriate;

6. access to a 24-hour emergency response through written emergency response procedures for handling emergencies and contact numbers for appropriate staff for after hours; and

a. For purposes of these provisions, after hours shall include holidays, weekends, and hours between 4:31 p.m. and 7:59 a.m. on Monday through Friday;

7. general supervision of personal needs funds retained for the client's use if specified in the service plan.

D. Client Records

1. SFC Providers shall ensure that the SFC caregiver complies with the following standards for client records.

a. Information about clients and services of the contract agency shall be kept confidential and shared with third parties only upon the written authorization of the client or his/her authorized representative, except as otherwise specified in law.

b. The SFC caregiver shall make all client records available to the department or its designee and any other state or federal agency having authority to review such records.

c. The SFC caregiver shall ensure the privacy of the client's protected health information.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2120.1.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:90 (January 2012).

§5091. Operational Requirements for Substitute Family Care Caregivers

A. The SFC caregiver(s) shall provide adequate environments that meet the needs of the clients.

B. The SFC caregiver's home shall be located within a 25 mile radius of community facilities, resources and services such as medical care, schools, recreation facilities, churches and other community facilities, unless a waiver is granted by the department.

C. The home of the SFC family shall not be used as lodging for any person(s) who is not subject to the prior approval certification process of the SFC family. The SFC family shall notify the administrator, or designee of the SFC provider, of any person(s) allowed to live in the home following the initial certification.

1. In a non-emergent situation, prior notification is required. In an emergent situation, notification shall be made within 48 hours of the additional person's move into the substitute's family home.

2. All persons residing with the SFC family, even on a non-permanent basis, shall undergo criminal record and background checks.

3. The SFC family shall accept persons requiring care or supervision only through the SFC provider with whom they have a current contract.

D. The SFC caregiver shall care for no more than two SFC clients in the caregiver's home. The SFC caregiver shall allow no more than three persons unrelated to the principal caregiver to live in the home. These three persons include the SFC clients.

E. The SFC caregiver shall have a stable income sufficient to meet routine expenses, independent of the payments for their substitute family care services, as

demonstrated by a reasonable comparison between income and expenses conducted by the administrator or designee of the SFC provider.

F. The SFC caregiver must have a plan that outlines in detail the supports to be provided. This plan shall be approved and updated as required by the SFC provider. The SFC caregiver shall allow only approved persons to provide care or supervision to the SFC client.

1. An adequate support system for the supervision and care of the participant in both on-going and emergent situations shall include:

a. identification of any person(s) who will supervise the participant on a regular basis which must be prior approved by the administrator or designee of the SFC agency provider;

b. identification of any person(s) who will supervise for non-planned (emergency) assumption of supervisory duties who has not been previously identified and who shall be reported to the agency provider administrator or designee within 12 hours; and

c. established eligibility for available and appropriate community resources.

G. The SFC caregiver and/or household shall receive referrals only from the licensed SFC provider with whom it has a contract.

H. SFC Caregiver's Home Environment

1. The home of the SFC caregiver shall be safe and in good repair, comparable to other family homes in the neighborhood. The home and its exterior shall be free from materials and objects which constitute a danger to the individual(s) who reside in the home.

2. SFC homes featuring either a swimming or wading pool must ensure that safety precautions prevent unsupervised accessibility to clients.

3. The home of the SFC caregiver shall have:

a. functional air conditioning and heating units which maintain an ambient temperature between 65 and 80 degrees Fahrenheit;

b. a working telephone;

c. secure storage of drugs and poisons;

d. secure storage of alcoholic beverages;

e. pest control;

f. secure storage of fire arms and ammunition;

g. household first aid supplies to treat minor cuts or burns;

h. plumbing in proper working order and availability of a method to maintain safe water temperatures for bathing; and

i. a clean and sanitary home, free from any health and/or safety hazards.

4. The SFC home shall be free from fire hazards such as faulty electrical cords, faulty appliances and non-maintained fireplaces and chimneys, and shall have the following:

a. operating smoke alarms within 10 feet of each bedroom;

b. portable chemical fire extinguishers located in the kitchen area of the home;

c. posted emergency evacuation plans which shall be practiced at least quarterly; and

d. two unrestricted doors which can be used as exits.

5. The SFC home shall maintain environments that meet the following standards.

a. There shall be a bedroom for each client with at least 80 square feet exclusive of closets, vestibules and bathrooms and equipped with a locking door, unless contraindicated by any condition of the client.

i. The department may grant a waiver from individual bedroom and square feet requirements upon good cause shown, as long as the health, safety and welfare of the client are not at risk.

b. Each client shall have his own bed unit, including frame, which is appropriate to his/her size and is fitted with a non-toxic mattress with a water proof cover.

c. Each client shall have a private dresser or similar storage area for personal belongings that is readily accessible to the client.

d. There shall be a closet, permanent or portable, to store clothing or aids to physical functioning, if any, which is readily accessible to the client.

e. The client shall have access to a working telephone.

f. The home shall have one bathroom for every two members of the SFC household, unless waived by the department.

g. The home shall have cooking and refrigeration equipment and kitchen and or dining areas with appropriate furniture that allows the client to participate in food preparation and family meals.

h. The home shall have sufficient living or family room space, furnished comfortably and accessible to all members of the household.

i. The home shall have adequate light in each room, hallway and entry to meet the requirements of the activities that occur in those areas.

j. The home shall have window coverings to ensure privacy.

I. Automobile Insurance and Safety Requirements

1. Each SFC caregiver shall have a safe and dependable means of transportation available as needed for the client.

2. The SFC caregiver shall provide the following information to the SFC provider who is responsible for maintaining copies in its records:

a. current and valid driver's licenses of persons routinely transporting the client;

b. current auto insurance verifications demonstrating at least minimal liability insurance coverage;

c. documentation of visual reviews of current inspection stickers; and

d. documentation of a driving history report on each family member who will be transporting the client.

3. If the client(s) are authorized to operate the family vehicle, sufficient liability insurance specific to the client(s) use shall be maintained at all times.

J. Client Records

1. The SFC caregiver shall forward all client records, including progress notes and client service notes to the SFC provider on a monthly basis. The following information shall be maintained in the client records in the SFC caregiver's home:

a. client's name, sex, race and date of birth;

b. client's address and the telephone number of the client's current place of employment, school or day provider;

c. clients' Medicaid/Medicare and other insurance cards and numbers;

d. client's social security number and legal status;

e. name and telephone number of the client's preferred hospital, physician and dentist ;

f. name and telephone number of the closest living relative or emergency contact person for the client;

g. preferred religion (optional) of the client;

h. Medicaid eligibility information;

i. medical information, including, but not limited to:

i. current medications, including dosages, frequency and means of delivery;

ii. the condition for which each medication is prescribed; and

iii. allergies;

j. identification and emergency contact information on persons identified as having authority to make emergency medical decisions in the case of the individual's inability to do so independently;

k. progress notes written on at least a monthly basis summarizing services and interventions provided and progress toward service objectives; and

i. Checklists alone are not adequate documentation for progress notes;

l. a copy of the client's ISP and any vocational and behavioral plans.

2. Each SFC family shall have documentation attesting to the receipt of an adequate explanation of:

a. the client's rights and responsibilities;

b. grievance procedures;

c. critical incident reports; and

d. formal grievances filed by the client.

3. All records maintained by the SFC caregiver shall clearly identify the:

a. date the information was entered or updated in the record;

b. signature or initials of the person entering the information; and

c. documentation of the need for ongoing services.

K. The SFC caregiver shall be required to take immediate actions to protect the health, safety and welfare of clients at all times.

1. When a client has been involved in a critical incident or is in immediate jeopardy, the SFC caregiver shall seek immediate assistance from emergency medical services and local law enforcement agencies, as needed.

2. If abuse, neglect or exploitation is suspected or alleged, the SFC caregiver is required to report such abuse, neglect or exploitation in accordance with R.S.40:2009.20 or any successor statute.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2120.1.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:91 (January 2012).

Subchapter L. Supervised Independent Living Module

§5093. General Provisions

A. Providers applying for the Supervised Independent Living Module under the HCBS license shall meet the core licensing requirements as well as the module specific requirements of this Section.

B. When applying for the SIL module under the HCBS provider license, the provider shall indicate whether the provider is initially applying as an SIL or as an SIL via shared living conversion process, or both.

C. Clients receiving SIL services must be at least 18 years of age. An SIL living situation is created when an SIL client utilizes an apartment, house or other single living unit as his place of residence.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2120.1.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:93 (January 2012).

§5094. Operational Requirements for the Supervised Independent Living Module

A. A provider shall ensure that the living situation is freely selected by the client. An SIL residence may be owned or leased by either the provider or the client. At the expense of the owner or lessee, a provider shall ensure that the living situation shall be:

1. accessible and functional, considering any physical limitations or other disability of the client;

2. free from any hazard to the health or safety of the client;

3. properly equipped with accommodations for activities of daily living;

4. in compliance with applicable health, safety, sanitation and zoning codes;

5. a living situation that affords the client's individual privacy;

6. arranged such that if there is more than one client in the living situation, the living environment does not conflict with the individual ISP of either client;

7. equipped with a functional kitchen area including space for food storage and a preparation area;

8. equipped with a functional private full bathroom. There shall be at least one full or half bathroom for every two clients residing at the SIL;

9. equipped with a living area;

10. equipped with an efficiency bedroom space or a separate private bedroom with a locking door, if not contraindicated by a condition of the client residing in the room:

a. There shall be at least one bedroom for each two unrelated clients living in the SIL;

b. Each client shall have the right to choose whether or not to share a bedroom and a bed with another client;

11. equipped with hot and cold water faucets that are easily identifiable. If an assessment has been made that the client is at risk of scalding, the hot water heater shall be adjusted accordingly;

12. equipped with functional utilities, including:

a. water;

b. sewer; and

c. electricity;

13. equipped with functional air conditioning and heating units which is capable of maintaining an ambient temperature between 65 and 80 degrees Fahrenheit throughout the SIL;

14. kept in a clean, comfortable home-like environment;

15. equipped with the following furnishings if owned or leased by a provider:

a. a bed unit per client which includes a frame, clean mattress and clean pillow;

b. a private dresser or similar storage area for personal belongings that is readily accessible to the resident. There shall be one dresser per client;

c. one closet, permanent or portable, to store clothing or aids to physical functioning, if any, which is readily accessible to the resident. There shall be one closet per bedroom;

d. a minimum of two chairs per client;

e. a table for dining;

f. window treatments to ensure privacy; and

g. adequate light in each room, hallway and entry to meet the requirements of the activities that occur in those areas; and

16. equipped with a functional smoke detector and fire extinguisher.

B. A provider shall ensure that any client placed in the living situation has:

1. 24-hour access to a working telephone in the SIL;

2. access to transportation; and

3. access to any services in the client's approved ISP.

C. The department shall have the right to inspect the SIL and client's living situation.

D. An SIL provider shall ensure that no more than four unrelated clients are placed in an apartment, house or other single living unit utilized as a supervised independent living situation.

1. A SIL living situation shall make allowances for the needs of each client to ensure reasonable privacy which shall not conflict with the program plan of any resident of the living situation.

2. No clients shall be placed together in a living situation against their choice. The consent of each client shall be documented in the clients' record.

E. Supervision

1. For purposes of this Section, a supervisor is defined as a person, so designated by the provider agency, due to experience and expertise relating to client needs.

2. A supervisor shall have a minimum of two documented contacts per week with the client. The weekly contacts may be made by telephone, adaptive communication technology or other alternative means of communication.

a. The supervisor shall have a minimum of one face-to-face contact per month with the client in the client's home. The frequency of the face-to-face contacts shall be based on the client's needs.

b. In the event that the client has been admitted to a hospital or other inpatient facility, a face-to-face contact in the facility may substitute for a face-to-face contact in the client's home.

c. Providers may make as many contacts in a day as are necessary to meet the needs of the client. However, only one of those contacts will be accepted as having met one of the two documented weekly contacts or the one monthly face-to-face contact.

3. Attempted contacts are unacceptable and will not count towards meeting the requirements.

F. In addition to the core licensing requirements, the SIL provider shall:

1. provide assistance to the client in obtaining and maintaining housing;

2. allow participation in the development, administration and oversight of the client's service plan to assure its effectiveness in meeting the client's needs;

3. assure that bill payment is completed monthly in accordance with the individual service plan, if applicable; and

4. assure that staff receive training in identifying health and safety issues including, but not limited to, scald prevention.

G. An SIL provider shall assess the following in conjunction with the client or client's legal representative when selecting the location of the SIL situation for the client:

a. risks associated with the location;

b. client cost;

c. proximity to the client's family and friends;

d. access to transportation;

e. proximity to health care and related services;

f. client choice;

g. proximity to the client's place of employment; and

h. access to community services.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2120.1.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:93 (January 2012).

§5095. Supervised Independent Living Shared Living Conversion Process

A. The SIL Shared Living Conversion process is a situation in which a home and community-based shared living model, for up to six persons, may be chosen as a living option for participants in the Residential Options Waiver or any successor waiver.

B. Only an existing ICF/DD group or community home with up to 8 beds as of promulgation of the final Rule governing these provisions, may voluntarily and permanently close its home and its related licensed, Medicaid certified and enrolled ICF/DD beds to convert to new community-based waiver opportunities (slots) for up to six persons in shared living model or in combination with other ROW residential options. These shared living models will be located in the community.

1. Notwithstanding any other provision to the contrary, an SIL Shared Living Conversion model shall ensure that no more than six ROW waiver clients live in an apartment, house or other single living situation upon conversion.

C. The DHH Office for Citizens with Developmental Disabilities (OCDD) shall approve all individuals who may be admitted to live in and to receive services in an SIL Shared Living Conversion model.

D. The ICF/DD provider who wishes to convert an ICF/DD to an SIL via the shared living conversion model shall be approved by OCDD and shall be licensed by HSS prior to providing services in this setting, and prior to accepting any ROW participant or applicant for residential or any other developmental disability service(s).

E. An ICF/DD provider who elects to convert to an SIL via the shared living conversion model may convert to one or more conversion models, provided that the total number of SIL shared living conversion slots; beds shall not exceed the number of Medicaid facility need review bed approvals of the ICF(s)/DD so converted.

1. The conversion of an ICF(s)/DD to an SIL via the shared living conversion process may be granted only for the number of beds specified in the applicant's SIL shared living conversion model application to OCDD.

2. At no point in the future may the provider of a converted SIL, which converted via the shared living conversion process, be allowed to increase the number of SIL slots approved at the time of conversion.

3. Any remaining Medicaid facility need review bed approvals associated with an ICF/DD that is being converted cannot be sold or transferred and are automatically considered terminated.

F. An ICF/DD provider who elects to convert to an SIL via the shared living conversion process shall obtain the approval of all of the residents of the home(s) (or the responsible parties for these residents) regarding the conversion of the ICF/DD prior to beginning the process of conversion.

G. Application Process

1. The ICF/DD owner or governing board must sign a conversion agreement with OCDD regarding the specific beds to be converted and submit a plan for the conversion of these beds into ROW shared living or other ROW residential waiver opportunities, along with a copy of the corresponding and current ICF/DD license(s) issued by HSS.

a. This conversion plan must be approved and signed by OCDD and the owner or signatory of the governing board prior to the submittal of a HCBS provider, SIL module licensing application to DHH-HSS.

2. A licensed and certified ICF/DD provider who elects to convert an ICF/DD to an SIL via the shared living conversion process shall submit a licensing application for a HCBS provider license, SIL Module. The ICF/DD applicant seeking to convert shall submit the following information with his licensing application:

a. a letter from OCDD stating that the owner or governing board has completed the assessment and planning requirements for conversion and that the owner or governing board may begin the licensing process for an HCBS provider, SIL Module;

b. a letter of intent from the owner or authorized representative of the governing board stating:

i. that the license to operate an ICF/DD will be voluntarily surrendered upon successfully completing an initial licensing survey and becoming licensed as an SIL via the shared living conversion process; and

ii. that the ICF/DD Medicaid facility need review bed approvals will be terminated upon the satisfactory review of the conversion as determined by OCDD, pursuant to its 90 day post conversion site visit; and

3. an executed copy of the conversion agreement.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2120.1.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:94 (January 2012).

Subchapter M. Supported Employment Module

§5099. General Provisions

A. The provider applying to be licensed as a supported employment provider agency shall meet all of the HCBS provider core licensing requirements with the exception of the following requirements. The supported employment provider agency is not required to:

1. return all telephone calls from clients within a reasonable amount of time, other than during working hours;

2. have written policies and procedures approved by the owner or governing body that addresses client funds and emergency preparedness;

3. have written policies and procedures for behavior management, provided that the provider has no client with behavior management issues;

4. have nursing services staff and direct care staff;

5. have a client's assessment of needs conducted by a registered nurse; and

6. maintain progress notes at the client's home.

B. The administrator of the supported employment provider agency shall be exempt from the education qualifications listing in the core licensing requirements of this Chapter.

C. The assessment of needs shall be done prior to placement of the client on a job site. A Medicaid HCBS comprehensive assessment approved by a DHH program office for a Medicaid recipient shall not substitute for the assessment of needs. A comprehensive plan of care approved by the department for Medicaid or waiver reimbursement shall not substitute for the ISP.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2120.1.

HISTORY NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:95 (January 2012).

Bruce D. Greenstein
Secretary

1201#068

RULE

Department of Health and Hospitals
Office of Public Health

Marine and Fresh Water Animal Food Products
(LAC 51:IX.325, 327, 330, 331 and 333)

In accordance with the Administrative Procedure Act, R.S. 49:950 et seq., that the state health officer acting through the Department of Health and Hospitals, Office of Public Health, pursuant to the authority in R.S. 40:4(A)(1), R.S. 40:5(2),(3), (5), (15), (17), (19), (20) and (21), and R.S. 56:437, has amended and revised Title 51 (Public Health—Sanitary Code), Part IX (Marine and Fresh Water Animal Food Products), by effecting substantive changes as outlined below. The changes are due to Act 1 of the 2011 Regular Session of the Louisiana Legislature.